EXAMINING THE USE OF ADMINISTRATIVE ACTIONS IN THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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EXAMINING THE USE OF ADMINISTRATIVE ACTIONS IN THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

WEDNESDAY, MAY 20, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:06 a.m., in Room 1100, Longworth House Office Building, Hon. Peter Roskam [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON OVERSIGHT

FOR IMMEDIATE RELEASE
Wednesday, May 13, 2015
No. OS–04

CONTACT: (202) 225–3625

Chairman Roskam Announces Hearing on Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act

Congressman Peter Roskam (R–IL), Chairman of the Subcommittee on Oversight, today announced that the Subcommittee will hold a hearing titled, "*Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act*." **The hearing will take place on Wednesday, May 20, 2015, in Room 1100 of the Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, June 3, 2015**. For questions, or if you encounter technical problems, please call (202) 225–3625 or (202) 225–2610.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available online at *http://www.waysandmeans.house.gov/*.

Chairman ROSKAM. The Committee will come to order.

Welcome to the Ways and Means Oversight Subcommittee hearing on Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act.

I will begin with an opening statement, and then we will yield to Mr. Lewis, the Ranking Member, when he arrives. He is on his way, but he has asked us to move ahead.

So, with that, today we are going to be taking a look at administrative actions, that is, unilateral actions by the President and the executive branch as they implement and administer the President's healthcare law. The question we examine today is: If one President could ignore parts of the healthcare law, can another President ignore the whole thing?

The issue goes to the core of our Committees' mission to conduct rigorous oversight. House rule 10 empowers us, as a Subcommittee, to determine whether laws and programs are being implemented and carried out in accordance with the intent of Congress. And while we consider these issues today, it is also important to remember the larger context.

The Affordable Care Act was passed by Democratic majorities in the House and Senate in 2010. It was signed into law by President Obama. If a President and Congress of one party can enact a law, but reconsider and alter it after enactment, then what can a different President in Congress do with the same law or any other? Do laws matter at all? What about the votes of the American people? Do they matter?

We are focusing specifically on executive actions relating to the Affordable Care Act, but don't lose sight of the critical importance of these issues at the core of our representative democracy. The question before us is not whether the Administration is implementing the healthcare law. It is whether the Administration is undermining the rule of law. And I believe the answer is yes.

The Administration is too eager to take unilateral actions to solve thorny political problems. It has created a false narrative that Congress is unwilling to take on these challenges. In fact, as we will hear today, Congress has amended the Affordable Care Act over a dozen times. The Administration's problem is acting out of expediency and not following the Constitution.

So the old phrase comes to mind that, "The road to hell is paved with good intentions." But the Constitution is clear. Congress writes the law. The President executes the law, period. The Presi-

dent cannot rewrite the law. If the President can make the law up as he pleases, there is no accountability.

Putting this incredible amount of power in the hands of one person completely erodes the delicate balance that the Founding Fathers established through checks and balances. Ultimately, too, it takes away the meaning of our votes as American citizens.

It is precisely because of this issue and the significance and the scope of the President's healthcare law that yesterday I introduced legislation to create a special Inspector General to monitor the Affordable Care Act. It is modeled after the special Inspectors General that Congress has created for Iraq and Afghanistan reconstruction and the Troubled Asset Relief Program, that together have produced taxpayer savings of almost $10 billion.

So an enterprise as big and complicated as national healthcare reform surely deserves the same level of oversight as the earlier endeavors. And, without objection, I will insert the findings of my SIGMA Act into the record.

[The submission of The Honorable Peter Roskam follows:]

.....

(Original Signature of Member)

114TH CONGRESS
1ST SESSION

H. R. _____

To establish the Office of the Special Inspector General for Monitoring the Affordable Care Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. ROSKAM introduced the following bill; which was referred to the Committee on _____

A BILL

To establish the Office of the Special Inspector General for Monitoring the Affordable Care Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Special Inspector General for Monitoring the ACA Act of 2015" or the "SIGMA Act of 2015".

SEC. 2. FINDINGS.

The Congress finds the following:

(1) The writing, passage, and implementation of the Affordable Care Act has utterly lacked transparency.

(2) Presidential candidate Barack Obama repeatedly promised that if elected President, he would hold open, public negotiations on health care reform among public and private stakeholders, including at a Democratic Presidential debate on January 31, 2008, when he said, ''That's what I will do in bringing all parties together, not negotiating behind closed doors, but bringing all parties together, and broadcasting those negotiations on C–SPAN so that the American people can see what the choices are, because part of what we have to do is enlist the American people in this process.''.

(3) Then-Senator Obama repeated this promise multiple times, including at an Ohio town hall on March 1, 2008, when he said, ''But here's the thing: we're gonna do all these negotiations on C–SPAN. So the American people will be able to watch these negotiations.''.

(4) Then-Senator Obama also repeated this promise at a Virginia town hall on August 21, 2008, when he said, ''I'm going to have all the negotiations around a big table. We'll have doctors and nurses

and hospital administrators. Insurance companies, drug companies—they'll get a seat at the table...But what we will do is, we'll have the negotiations televised on C–SPAN, so that people can see who is making arguments on behalf of their constituents, and who are making arguments on behalf of the drug companies or the insurance companies. And so, that approach, I think is what is going to allow people to stay involved in this process.".

(5) In a September 26, 2011, interview, Brian Lamb, the CEO of C–SPAN confirmed the negotiations of the health reform law had not been broadcast publicly, noting, "The President said that they were all going to be on C–SPAN. He never asked us.".

(6) President Obama, in leading the national health reform debate, broke his promise, admitting in a January 25, 2010, interview with ABC News that locking the public out of key health reform discussions was a "mistake" and explaining, "We had to make so many decisions quickly in a very difficult set of circumstances that after awhile, we started worrying more about getting the policy right than getting the process right. But I had campaigned on process—part of what I had campaigned on was

changing how Washington works, opening up, transparency and I think it is—I think the health care debate as it unfolded legitimately raised concerns not just among my opponents, but also amongst supporters that we just don't know what's going on. And it's an ugly process and it looks like there are a bunch of backroom deals.".

(7) On March 9, 2010, then-Speaker of the House Nancy Pelosi said of what would become the Affordable Care Act, "We have to pass the bill so that you can find out what is in it.".

(8) Dr. Jonathan Gruber, a professor of economics at the Massachusetts Institute of Technology, was awarded a contract by the Department of Health and Human Services to provide "technical assistance in evaluating options for national healthcare reform" due to his "proprietary statistically sophisticated micro-simulation model" which could assess the impact of changes in Federal health care policies.

(9) Dr. Gruber described himself as a health reform architect who contributed to the crafting of the Affordable Care Act in a 2012 opinion editorial, noting, "Several of the architects of Massachusetts reform, including myself, worked closely with the Ad-

ministration and Congress to translate the lessons from Massachusetts onto the national stage.".

(10) Dr. Gruber's MIT biography has described him as "a key architect" of the Massachusetts health reform effort and a 2009 and 2010 "technical consultant" who "worked with both the Administration and Congress to help craft the Patient Protection and Affordable Care Act.".

(11) An October 11, 2011, report by NBC News described White House visitor logs that show Dr. Gruber had at least five meetings at the White House in 2009 in the lead up to the passage of the Affordable Care Act, including a meeting in the Oval Office with President Obama to evaluate options for national health reform.

(12) In a video posted April 12, 2012, by the Obama presidential campaign to YouTube, Dr. Gruber states that he went "down to Washington to help President Obama develop his national version of that law.".

(13) A March 28, 2012, article in The New York Times reports that "After Mr. Gruber helped the administration put together the basic principles of the proposal, the White House lent him to Capitol

Hill to help congressional staff members draft the specifics of the legislation.".

(14) In a January 18, 2012, lecture on the structure of the Affordable Care Act, Dr. Gruber refers to the law's small business tax credits as a portion of the bill that he "actually wrote.".

(15) Dr. Gruber's initial contract with the Department of Health and Human Services (HHS) was for $297,000, and later a Federal grant of $95,000 brought his total Federal compensation for work on the Affordable Care Act to at least $392,000.

(16) In 2009, the White House annual report to Congress on presidential staff salaries lists that twenty-two White House staffers made the highest presidential staff salary rate of $172,200, including the White House Chief of Staff, senior advisers, White House Counsel, and National Security Adviser.

(17) In 2010, the White House annual report to Congress on Presidential staff salaries lists that twenty-three White House staffers made the highest Presidential staff salary rate of $172,200, again including the President's top management, policy, communications, and security advisers.

(18) In 2009 and 2010, each of President Obama's most senior White House staff received less compensation than Dr. Gruber.

(19) In a November 5, 2012, speech at the University of Rhode Island, Dr. Gruber described the mechanism of the Affordable Care Act, stating, "It's a very clever, you know, basic exploitation of the lack of economic understanding of the American voter.".

(20) At an October 17, 2013, panel at the University of Pennsylvania, Dr. Gruber described the Affordable Care Act, stating, "This bill was written in a tortured way to make sure CBO did not score the mandate as taxes. If CBO scored the mandate as taxes, the bill dies. Okay, so it's written to do that.".

(21) In the same speech, Dr. Gruber stated that, "if you had a law which said that healthy people are going to pay in you made explicit healthy people pay in and sick people get money, it would not have passed.".

(22) Dr. Gruber went on to claim, "Lack of transparency is a huge political advantage. And basically, call it the stupidity of the American voter or

whatever, but basically that was really, really critical for the thing to pass.''.

(23) Since the passage of the Affordable Care Act, President Obama called for a new, more transparent approach to the health reform law moving forward, saying in a January 25, 2010, ABC News interview, ''The process didn't run the way I ideally would like it to and that we have to move forward in a way that recaptures that sense of opening things up more.''.

(24) The Obama Administration's implementation of the Affordable Care Act has been marked by Executive overreach.

(25) On at least 28 occasions, President Obama and his administration have unilaterally delayed, extended, or changed provisions of the Affordable Care Act, including in contravention of the law and the Constitution of the United States.

(26) Section 1513 of the Patient Protection and Affordable Care Act (26 U.S.C. 4980h note) requires applicable large employers with more than 50 full-time employees to provide qualifying health insurance to their employees or pay a fine, and the effective date under such section specified the amend-

ments made by such section applied to months beginning after December 31, 2013.

(27) Contrary to the plain meaning of the statutory requirement, and acting without authority provided by law, the Internal Revenue Service published in the Federal Register Notice 2013–45 to change the effective date of the employer mandate requirement, stating, "Section 1513(d) of the Affordable Care Act provides that section 4980H applies to months after December 31, 2013; however Notice 2013–45, issued on July 9, 2013, provides as transition relief that no assessable payments under section 4980H will apply for 2014.".

(28) On July 12, 2013, the Director for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services denied the request for exemption from certain Affordable Care Act requirements made by representatives of the United States territories, writing to the Secretary of Commerce for the Commonwealth of the Northern Mariana Islands, "However meritorious your request might be, [the Department of Health and Human Services] is not authorized to choose which provisions [of the Affordable Care Act]. . .might apply to the territories.".

(29) A year later, on July 16, 2014, the Administrator of the Centers for Medicare & Medicaid Services notified representatives of the United States territories that they would in fact receive an exemption from requirements under the Affordable Care Act, despite the previous explanation from CMS that CMS does not have the legal authority to provide such an exemption. As the CMS Administrator now rationalized, ''Currently, the Department uses the existing Public Health Service Act (PHS Act) definition of 'State' for new PHS Act requirements and funding opportunities included in title I of the Affordable Care Act. Under this definition, the new market reforms in the PHS Act apply to the territories. We have been informed by representatives of the territories that this interpretation is undermining the stability of the territories' health insurance markets. After a careful review of this situation and the relevant statutory language, HHS has determined that the new provisions of the PHS Act enacted in title I are appropriately governed by the definition of 'State' set forth in that title, and therefore that these new provisions do not apply to the territories.''.

(30) The Obama Administration has claimed that the Affordable Care Act will save money and improve the economy, with WhiteHouse.gov stating, ''In keeping with the President's pledge that reform must fix our health care system without adding to the deficit, the Affordable Care Act reduces the deficit, saving over $200 billion over 10 years and more than $1 trillion in the second decade. The law reduces health care costs. . .[and] is improving our economic competitiveness[.]''.

(31) $70.2 billion of the White House's estimated savings was to come from the Community Living Assistance Services and Supports (CLASS) Act provisions of the Affordable Care Act, a program that was deemed actuarially unsound and never implemented by the Obama Administration.

(32) An April 2010 report from the Office of the Actuary for the Centers for Medicare & Medicaid Services describes that additional savings under the Affordable Care Act were to be paid for with Medicare Fee-for-Service and Medicare Advantage cuts and reductions in payments to hospitals, skilled nursing facilities, and home health centers. These cuts have been delayed and may never materialize. Even if implemented, the projected savings may

never accrue as the CMS Actuary's report concludes that such cuts will cause about 15% of hospitals and post-acute care facilities like nursing homes to go out of business.

(33) $52 billion in deficit reduction savings was projected to come from employer penalties paid to the Government for failure to comply with the employer mandate requirement to provide employees health insurance, a requirement that the Obama Administration has repeatedly delayed and modified, causing penalties and associated savings to not accrue.

(34) Initial estimates of savings under the Affordable Care Act projected at least $15.5 billion in savings over the next decade attributable to Medicare cuts through the Independent Payment Advisory Board, which has not yet been appointed and through which no cuts or savings have been realized.

(35) On September 9, 2009, President Obama pledged to a joint session of Congress, "I will not sign a [health care reform] plan that adds one dime to our deficits—either now or in the future.".

(36) The Congressional Budget Office estimated in February 2014 that health insurance subsidies under the Affordable Care Act would cost the

Federal Government $47 billion in fiscal year 2015 and $1,197 trillion over fiscal years 2015–2024.

(37) The Committees on Finance and Health, Education, Labor, and Pensions of the Senate estimated in September 2014 that the Affordable Care Act will add at least $340 billion to Federal budget deficits.

(38) Dr. Gruber stated, ''The [Affordable Care Act] isn't designed to save money.''.

(39) On at least 37 occasions, President Obama or a top official in the executive branch repeated the promise that ''If you like the [health insurance] plan you have, you can keep it. If you like the doctor you have, you can keep your doctor.''.

(40) The Associated Press calculated at least 4.7 million Americans had their health insurance cancelled for 2014 and later, when the President issued a last-minute fix to try to prevent these cancellations as required by the Affordable Care Act, the changes came too late for approximately 2.4 million Americans to keep the plans they had and liked.

(41) The nonpartisan, fact-checking publication Politifact rated ''If you like your health care plan, you can keep it.'' as the Lie of the Year for 2013.

(42) Then-Presidential candidate Barack Obama repeatedly promised that, if elected President, his national health care reforms would, "cut the cost of a typical family's premium by up to $2,500 a year.".

(43) A November 2013 analysis by the Manhattan Institute calculates that the Affordable Care Act would increase individual marketplace health insurance premiums by 41 percent nationwide between 2013 and 2014.

(44) A December 2013 study by Health Pocket, Inc., found that the average individual deductible for a Bronze plan was $5,081 a year, a 42 percent increase from the average plan purchased by an individual in 2013.

(45) A February 2013 study by Health Pocket Inc., found that exchange plans under the Affordable Care Act averaged a 34 percent increase in drug-cost sharing compared to copayment and coinsurance rates in the pre-Affordable Care Act market. For the sickest patients needing specialty drugs, the study found copayments increased by 226 percent under a Bronze plan via the Affordable Care Act.

(46) A December 2013 study by McKinsey and Company found that insurers offered almost three

times as many narrow or ultranarrow network plans in 2014 compared to 2013. Fully 70 percent of Affordable Care Act plans analyzed had narrow or ultranarrow network coverage, meaning coverage for fewer doctors and hospitals than plans sold on the individual market before the law took effect.

(47) Details consumers require to make informed decisions about their health care plan coverage under the Affordable Care Act have been withheld or lacked transparency.

(48) On September 26, 2013, President Obama said, ''It will say clearly what each plan covers, what each plan costs. The price will be right there. It will be fully transparent . . . And so if you've ever tried to buy insurance on your own, I promise you this is a lot easier. It's like booking a hotel or a plane ticket.''.

(49) HealthCare.gov was established as the website to implement the Federal exchange portion of the Act at a cost of as much as $840 million, including more than $150 million in cost overruns, according to the Government Accountability Office in March 2014.

(50) On October 1, 2013, HealthCare.gov launched without adequate security testing, leaving

the approximately 250,000 unique users it drew not only vulnerable to identity theft by hackers, but unable to even use the site, as the website was demonstrably unable to handle even 1,100 simultaneous users.

(51) For the subsequent months after its launch, HealthCare.gov continued to be plagued by crippling malfunctions, and the dismal performance of the website led only to problems and frustration for millions of Americans.

(52) A June 2013 study by the Department of Health and Human Services' Office of Inspector General revealed that software designed by a principal HealthCare.gov vendor was highly insecure and put the information of more than 6 million Medicare beneficiaries at ''greater risk from malware, inappropriate access or theft''.

(53) An April 2014 study by Avalere Health determined that 38 percent of health insurance plans offered on the exchanges under the Affordable Care Act had no information about drug coverage available. Avalere also found that nearly 1 in 4 plans offered insufficient information on which doctors and hospitals are covered.

(54) In September 2014, the Administrator of the Centers for Medicare and Medicaid Services reported to Congress that 7.3 million Americans had enrolled in plans through exchanges under the Affordable Care Act, meeting enrollment targets estimated by the Congressional Budget Office and held as a goal by the Obama Administration.

(55) Four months later, HHS Secretary Burwell stated that this enrollment data was a ''mistake'' that included some 400,000 dental insurance enrollments, the inclusion of which allowed the administration to claim for months that the Affordable Care Act was performing as anticipated which was not in fact a true or accurate representation of the data they had, but would not release to the public.

(56) Since implementation of the ACA began, the HHS Secretary has granted over $1 billion in Federal taxpayer dollars to states to help build websites for their own state-based exchanges, yet development and usability issues on short timelines repeatedly caused these same states to seek different options for the 2015 open enrollment period, including opting to revert to enrolling via the federal HealthCare.gov website.

(57) The Affordable Care Act provides opportunities for fraud within subsidy and tax credit issuance.

(58) A September 2013 report by the Treasury Inspector General for Tax Administration concluded that, ''the IRS's existing fraud detection system may not be capable of identifying ACA refund fraud or schemes prior to the issuance of tax return refunds.''.

(59) A July 2014 undercover study by the Government Accountability Office determined that fictitious applicants were able to obtain health insurance coverage and taxpayer-funded subsidies on the Federal exchanges using falsified documents in 11 out of 12 cases.

(60) The Affordable Care Act has had a negative impact on the American economy.

(61) A February 2014 calculation by the Congressional Budget Office found the Affordable Care Act will significantly harm the American economy, reducing the number of hours worked by millions of full-time employees worth of hours. The CBO study noted, ''The reduction in CBO's projections of hours worked represents a decline in the number of full-

time-equivalent workers of about 2 million in 2017, rising to about 2.5 million in 2024.".

(62) History has shown the Special Inspector General model to be successful at saving taxpayer dollars and rooting our waste, fraud, and abuse in large Federal Government programs.

(63) Congress and the President have enacted legislation creating Special Inspectors General on three occasions, including to oversee Federal spending and policy implementation for Afghanistan reconstruction (SIGAR), Iraq reconstruction (SIGIR), and the Troubled Asset Relief Program (SIGTARP).

(64) SIGAR, SIGIR, and SIGTARP have successfully conducted audits and investigations saving the Federal Government billions in waste, fraud, and abuse, and have helped to identify and prosecute theft and corruption.

(65) As of an October 2014 report, SIGAR has produced 57 referrals for suspension and debarment of Federal contractors and employees and produced over $500 million in direct taxpayer savings.

(66) According to its final report, SIGIR cost $245 million to operate, but resulted in $645 million in direct savings to the Federal Government, in addition to producing $192 million in seizures and

court-ordered penalties, as well as 90 criminal convictions.

(67) As of an October 2014 report, SIGTARP has produced 146 convictions and $7.38 billion in fines, penalties, and restitution to the Government and victims.

(68) On August 5, 2014, the Associated Press reported that 47 Federal inspectors general sent an unprecedented joint letter to Congress to decry, ''Obama administration efforts to delay or stall their investigations,'' citing three examples where Federal agencies have hindered substantive inspector general oversight work by refusing to provide information or documents they are entitled to under the law.

(69) The letter from more than half of the Federal Government's independent inspectors general correctly states, ''Section 6(a)(1) of the IG Act reflects the clear intent of Congress that an Inspector General is entitled to timely and unimpeded access to all records available to an agency that relate to that Inspector General's oversight activities. The constricted interpretations of Section 6(a)(1) by these and other agencies conflict with the actual language and Congressional intent. The IG Act is clear: no law restricting access to records applies to In-

spectors General unless that law expressly so states, and that unrestricted access extends to all records available to the agency, regardless of location or form.".

(70) Congress has a responsibility to exercise prudent stewardship of public dollars, to ensure that laws are well and faithfully executed by the executive branch, to provide for efficacious services for the American people, and to ensure that those who cheat, steal from, or defraud the Federal Government are held to account.

SEC. 3. SPECIAL INSPECTOR GENERAL FOR MONITORING THE AFFORDABLE CARE ACT.

(a) OFFICE OF SPECIAL INSPECTOR GENERAL.—There is hereby established the Office of the Special Inspector General for Monitoring the Affordable Care Act (in this section, referred to as the "Office") to carry out the duties described under subsection (e).

(b) APPOINTMENT OF INSPECTOR GENERAL; REMOVAL.—

(1) APPOINTMENT.—The head of the Office is the Special Inspector General for Monitoring the Affordable Care Act (in this section referred to as the "Special Inspector General"), who shall be appointed

Chairman ROSKAM. Our hearing today will review some of the changes the President has made to the Affordable Care Act without congressional approval and the impact of those changes.

And, to do this, we have four extremely knowledgeable witnesses: Elizabeth Papez, a partner at the law firm of Winston & Strawn; Jonathan Adler, Professor of Law at Case Western Reserve University; Grace-Marie Turner, President of the Galen Institute; and Robert Weiner, a partner at the law firm of Arnold & Porter.

And I want to thank all of you for attending and I look forward to the insight and perspectives that you have. I know you are busy people. You are being very generous with us with your time today, and I am grateful.

Mr. RANGEL. Mr. Chairman.

Chairman ROSKAM. Mr. Rangel, let me finish my statement and then I will——

Mr. RANGEL. I apologize. That pause was misinterpreted by me.

Chairman ROSKAM. No trouble. Let me just continue, and I will recognize you.

Defenders of the law claim that the President's actions are routine uses of Administration discretion. However, as we will discuss today, Administration discretion is not unlimited.

In many ways, the actions are unprecedented in American history, as some of our witnesses will describe. I expect one witness will shrug this off. But I don't think the Founders would shrug. And, in fact, they were very apprehensive about just this situation.

And here is the proof: Our second President, John Adams, wrote this in part in the Massachusetts constitution. He said this: "In the government, the legislative department shall never exercise executive and judicial powers, the executive shall never exercise legislative and judicial powers, and judicial shall never exercise legislative and executive powers, so that it may be a government of laws and not of men."

I want to emphasize that this is not hypothetical. This is not esoteric. This is not distant. This is at the very core of who we are as people. The unchecked use of unilateral executive action creates a dangerous and damaging precedent. And today we are here to learn a cautionary tale: Beware of a bad process that yields the result you desire. It can just as easily be used against you.

In closing, this principle was brilliantly portrayed in the film, "*A Man for All Seasons*." You will recall that this is the story of Sir Thomas More. And in a dramatic scene, an associate of his made the argument that he would cut down all the laws of England in order to get at Satan himself. More retorts that he would give the devil the benefit of the law for his own safety's sake. And let's not forget that laws exist to protect us.

I know that Members of both sides of this Committee have strong feelings on this issue. I am sensing that Mr. Rangel is so enthusiastic that he is seeking my recognition even now. And I look forward to our discussion.

And, with that, Mr. Rangel, I am happy to recognize you. We are waiting for Mr. Lewis, who asked us to go ahead. But, with that——

Mr. RANGEL. I want to appreciate your recognition.

I have in the audience a young student that is following me around for today for the purposes of learning more about the Congress. And so I can't thank you enough for the eloquent history lesson that you have given today. And notwithstanding some people's thought, I was not really here when the Founding Fathers drafted the Constitution.

But it would help, even before Mr. Lewis gets here, as to where would you want this hearing to conclude, because I am still looking for that avenue where we can reach a bipartisan conclusion.

And having seen your party ask for repeal of this law 55 times and having the U.S. Supreme Court saying that it is constitutional and recognizing that, in counting the numbers, it doesn't look like we are going to override a veto and, since Larry Foster is here, before Mr. Lewis can get here, what is the object of this hearing today? What would you want to conclude?

Because I am enthusiastic to try to show Mr. Foster that I am so anxious before the President's term is over to find out that you decided to do something constructive to make the Affordable Care Act more effective.

Chairman ROSKAM. Well, Mr. Rangel, I appreciate that opportunity to bring to your attention these witnesses, who I think are going to give us a perspective that is incredibly valuable.

And let's turn to them and invite them to give us some insight. And I think that they are going to span a spectrum and give us a wide range of opinions on some of these areas.

And so my hope is that both you and the student who has been following you for this period of time will come away edified from this. And I look forward to your comments as well.

Now, the Ranking Member, Mr. Lewis, has joined us.

Mr. RANGEL. Well, he is not only our Ranking Member, but he is an icon and a breath of fresh air for the entire world. And I am so glad that Mr. Foster is able to see that we have some outstanding statesmen on our Committee. And thank you so much for the courtesy, Mr. Chairman.

Chairman ROSKAM. I will echo your descriptions of Mr. Lewis.

And with Mr. Lewis, that is as good as it gets. We will turn to you for your opening statement.

Mr. LEWIS. Thank you very much, Mr. Chairman and fellow Members on both sides. I want to thank you for being so patient.

I want to apologize to you, Mr. Chairman. I was down at the controller's office speaking to all of the staff there and other agencies, but I am honored and delighted to be here.

I want to thank the witnesses for being here. Good morning.

Mr. Chairman, thank you for holding this hearing. I have said that it is good to be here to see each and every one of you.

Let me begin by saying what I have said at countless other hearings: The Affordable Care Act works. It was the right thing to do. It was the just thing to do. And it was long overdue.

I believe in my core that health care is a basic human right. It is not something that should be reserved for a select few, for the rich, or for the wealthy. The health reform law provides real benefits to American families. Over 16 million people who were previously uninsured now have health insurance.

Under the law, more than 100 million people with preexisting conditions can no longer be denied coverage. Millions of young people can stay on the insurance of their parents until age 26. In addition, over 9 million hardworking Americans across the United States receive tax credit to make their health insurance affordable, just as Congress intended.

Mr. Chairman, today's hearing should not be a platform for continued attacks on the health reform law. Instead, we should come together and focus on how to further improve health care for all Americans. Each and every one of us has a responsibility to make this country better for the least among us and for generations yet unborn. We have a duty to speak up and speak out on behalf of those that have no one to stand up for them.

The Administration acted, as Republican and Democratic Administrations have before them, to implement a law in a manner that considers and reflects the importance of the mission. It is time for each and every one of us to face the truth. The Affordable Care Act is the law of the land, and we must do all we can to strengthen and improve it. Tearing it down is simply not an option.

Thank you, Mr. Chairman.

Chairman ROSKAM. Thank you, Mr. Lewis.

I think this debate is framed up very, very well. So Mr. Lewis—I want to pick up on one of his comments in that this is not really a forum today to debate the merits of the Affordable Care Act.

That is well litigated. It is, you know, well explained. We have very strong feelings. This Committee has been at the heart of some of those debates, and it is really no secret what our different views are.

So we want to go deeper than that. We want to go now to this foundational question. That is what I would characterize as unilateral action. Others may characterize it differently. But you know what I am saying, the use of executive action and whether it is operating in the framework that is legal.

So we will hear from our panel in this order: Grace-Marie Turner, President of the Galen Institute; Jonathan Adler, the Johan Verheij Memorial Professor of Law and Director of the Center for Business Law and Regulation at the Case Western Reserve University School of Law; Elizabeth Papez, partner at Winston & Strawn and a Member of the Adjunct Faculty at the George Washington University Law School, who was formerly Deputy Assistant Attorney General of the Office of Legal Counsel at the U.S. Department of Justice; and Robert Weiner, a partner at Arnold & Porter.

The Committee has received your written statements, and they will be made a formal part of the hearing record. You will have 5 minutes to deliver your remarks.

And, Ms. Turner, we will begin when you are ready. Thank you.

STATEMENT OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Ms. TURNER. Thank you, Chairman Roskam. Thank you, Ranking Member Lewis and Members of the Committee. I really appreciate the opportunity to talk today with you about the Administration's actions in implementing the Affordable Care Act.

Professor Adler and Ms. Papez will discuss in their testimony some of the more prominent regulatory changes the Administration has made contrary to the language of the statute. The Galen Institute has chronicled many of the changes made to the ACA, and I will be talking about some of the other less prominent ones today.

And we count, as I said, at least 50 changes. Thirty-one have been made by the Administration, 17 passed by Congress and signed into law by the President, and two made by the Supreme Court. I have appended that list to my testimony.

Just a few examples. Allowing people to self-attest to their eligibility for subsidies was not part of the law. In newly discovered conflicts between the regulation and the statute, the law provides exchange subsidies for people under 100 percent of poverty as well as unlawful immigrants, contrary to the language of the statute.

And it also provides illegal bonus payments to try to postpone cuts to the Medicare Advantage plans. The nonpartisan Government Accountability Office called for the Administration to cancel this $8.3 billion program when it was giving quality bonus payments to plans that were mediocre and sometimes not even that. The Administration has ignored the GAO and Congress' demands to stop the illegal payments.

The Administration has also been criticized for its lack of transparency in the financing and implementation of the law. For example, the Administration last year issued $300 million in solvency funds to co-ops. There has been no explanation of the criteria used for making those decisions and why some received added funding and others did not.

In addition, Ways and Means Chairman Paul Ryan has asked Treasury to explain $3 billion that it has been spending in cost-sharing reduction spending never authorized by Congress. The issue is part of a lawsuit filed by House Speaker John Boehner.

The Administration claims the payments were legal, but it undercut its own argument when HHS asked Congress for appropriation to finance the payments. Congress refused, but the government continued to make the payments to insurance companies anyway.

There have been numerous instances where the Administration has made what many Members of Congress consider to be good changes to the law, but not within the statutory authority. And Congress has said, "Okay. We will go along with that" and, in fact, has passed on a bipartisan basis a number of provisions, for example, when the Administration issued its blog post in 2013 announcing the employer mandate delay.

The House of Representatives later that month passed legislation to say, "We will give you authorization to delay the mandate." The President said he would veto that legislation if it reached his desk, which it did not because it died in the Senate.

The House later that year had bipartisan support for the Keep Your Health Plan Act of 2013. It would give legal authority for the Administration to delay implementation of some health plans that did not comply with ACA requirements. The Administration threatened to veto that as well. The Administration has claimed it has made the changes through regulation because Congress has refused to consider legislative fixes, but that also is not true.

The repeal of the CLASS Act, the repeal of the 1099 reporting requirement, and the Medicaid fix all were passed by Congress, signed into law by the President, showing that the President is able to get Congress to act on changes to the law. The ACA has caused enormous disruption throughout the health sector. There were fixes that were needed, but the Administration does not have the authority to fix the legislation. It must implement it as written.

Mr. Chairman, I believe the evidence that will be presented today shows the need for your call for a special Inspector General to monitor the ACA. The Administration has spent—and I would say wasted—billions of dollars in taxpayer money in implementing the Affordable Care Act with eight different agencies charged with overseeing implementation of this law. It is very difficult for any one Inspector General to oversee the implementation and to really make sure the law is being properly implemented and that the taxpayer dollars are being well spent.

So I commend you for the SIGMA Act, Mr. Chairman, and I look forward to your questions.

[The prepared statement of Ms. Turner follows:]

A not-for-profit health and tax policy research organization

Testimony before the
Ways and Means Subcommittee on Oversight
United States House of Representatives

Rep. Peter Roskam, Chairman
Rep. John Lewis, Ranking Member

Hearing on

Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act

May 20, 2015

Testimony presented by
Grace-Marie Turner
President, Galen Institute

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"Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act"

Ways and Means Subcommittee on Oversight

May 20, 2015
Grace-Marie Turner, Galen Institute

Chairman Roskam, Ranking Member Lewis, and members of the committee, thank you for the opportunity to testify today on the use of administrative actions to implement the Affordable Care Act.

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. I served as an appointee to the Medicaid Commission from 2005-2006, as a member of the Advisory Board of the Agency for Healthcare Research and Quality from 2005 to 2007, and as a congressional appointee to the Long Term Care Commission in 2013.

The U.S. Supreme Court is considering a question that goes to the heart of the issue before the committee today. Did the Obama administration, through the Internal Revenue Service, have legal authority to allow premium assistance tax credits to be available in federally-facilitated health insurance exchanges? Or are the credits available only through an "Exchange established by the State," as the law specifies numerous times.

The court will decide that question within a month. I understand other witnesses today will be addressing issues in *King v Burwell*. But this is by no means the administration's only controversial action involving regulatory interpretation that challenges the language of the statute. The Galen Institute has been chronicling changes made to the Affordable Care Act since it was enacted in 2010, and we count at least 50 changes – 31 of them made by the administration. In addition, there have been 17 changes passed by Congress and signed into law by President Obama, and two changes made by the Supreme Court. I have appended our list to my testimony.[1]

Today, I will discuss 1) examples of actions by the administration that are clearly contrary to the statute; 2) failed and successful congressional actions to provide legal authority to changing the law; and 3) additional changes only now being uncovered.

Administration actions contrary to the statute

Many of the changes the administration has made through regulation are not based upon the language of the statute. A few examples:

- *Employer mandate delay*: An announcement leaked on July 2, 2013, that the administration would not take enforcement action until the beginning of 2015 against employers that fail to comply with the law's employer mandate requirements.[2] The ACA requires the provision to have taken effect on January 1, 2014. The administration subsequently announced an additional change, allowing employers with at least 50 but fewer than 100 employees an additional year to comply with the law.

- *Self-attestation*: Because of the difficulty of verifying income and employment after the delay of the employer reporting requirement described above, the administration decided to allow "self-attestation" of income and eligibility by people applying for health insurance in the exchanges.[3] Besides being contrary to the requirements in the statute, this has caused a cascade of hardship for people who understated their income. When they filed their income tax returns with the IRS this spring, they were required to reconcile the amount of subsidy they received with their actual income. More than half by one estimate had to pay back some or all of the subsidy the government had paid to health insurance companies on their behalf to reduce their monthly premiums. H&R Block estimates that 52 percent of its customers who received health coverage through the insurance exchanges in 2014 owed an average subsidy repayment of $530.[4]

- *Medicare Advantage cuts:* The administration continues to resist efforts by government auditors to comply with the law regarding payments to Medicare Advantage plans. To pay for expanded Medicaid and exchange insurance, the ACA calls for significant cuts to the popular MA program, which provides seniors with access to private health plans within Medicare.

  The nonpartisan Government Accountability Office called for the administration to cancel an $8.3 billion program it has tapped to pay "quality bonuses" to Medicare Advantage insurance plans. The administration has used the bonus payments to postpone the pain of cuts to MA plans that are called for in the law. Most of the money has gone to plans rated average or worse. The GAO concluded, "The Secretary of HHS should cancel the MA Quality Bonus Payment Demonstration and allow the MA quality bonus payment system established by PPACA to take effect. If, at a future date, the Secretary finds that this system does not adequately promote quality improvement, HHS should determine ways to modify the system, which could include conducting an appropriately designed demonstration."[5] The administration ignored the GAO's recommendation, and it also has ignored demands from Congress to stop the illegal payments.

Other controversial administration actions include several decisions to permit insurers to renew noncompliant policies in the individual and small group markets until in some cases October 1, 2016, even though the law explicitly says that plans must be compliant with the law's coverage standards no later than January 1, 2014.[6] The administration also has created special enrollment periods that have exempted individuals from fines and penalties called for in the statute.[7] I refer you to the appendix in my testimony for additional examples of the administration's regulatory changes to the law.

Lack of transparency

The administration also has been criticized for its lack of transparency in its financing of the implementation of the law. For example:

- *Co-op funding:* The administration released a list on December 22, 2014, of $300 million it had allocated in "solvency funds" last year to Consumer Operated and Oriented Plan (co-op) plans.[8] There is no explanation of the criteria used to determine why some co-ops received added federal funding and others didn't and why some received very generous awards and others much smaller amounts – or nothing. Nor is there any explanation about who decides which co-ops fail and which get additional infusions of federal funds. The branch of CMS in charge of overseeing the co-op program, the Center for Consumer Information & Insurance Oversight (CCIIO), is supposed to allow the various co-ops to draw down the funds in increments as they meet or exceed developmental milestones – but those milestones remain confidential contractual agreements that have not been disclosed to the public.

- *Cost-sharing reductions:* Treasury Department has rebuffed a request by Ways and Means Chairman Rep. Paul Ryan to explain $3 billion in payments the administration has made to health insurers even though Congress never authorized the spending through annual appropriations.[9] The payments to insurers are known as cost-sharing subsidies designed to limit out-of-pocket costs for certain low income individuals for health insurance deductibles, co-payments, and co-insurance. But Congress never authorized any money to make these payments to insurers in its annual appropriations. The administration made the payments anyway.

  The issue is part of the lawsuit filed by House Speaker John Boehner. Administration lawyers contend that congressional leaders are wrong, saying in a legal brief, "The cost sharing reduction payments are being made as part of a mandatory payment program that Congress has fully appropriated." But the administration undercut its own argument when HHS asked[10] Congress for an annual appropriation of $4 billion to finance the cost-sharing payments in 2014 and another $1.4 billion "advance appropriation" for the first quarter of fiscal year 2015, "to permit CMS to reimburse issuers …" The request was an acknowledgement that HHS needs congressional appropriations to make the payments. Congress rejected the request, but the administration made the payments to insurers anyway.

Congressional attempts to provide statutory authority to administrative changes to the law

There have been numerous instances when the administration has made what many Members of Congress consider to be an illegal change to the law but a change with which many in Congress agree. Congress has attempted to pass legislation to give legal standing to the change but has been rebuffed by the administration. For example:

- *Employer mandate delay:* When the administration issued its blog post on July 2, 2013, announcing the employer mandate delay, the House of Representatives later that month passed legislation that would have given legal standing to the delay. But the White House issued a Statement of Administration policy saying that the president would veto the legislation if it were to reach his desk. The legislation, which passed the House with bi-partisan support to grant a legal delay of the employer mandate, never reached the president's desk because it died in the Senate.[11]

- *Keep your Health Plan:* Similarly, the House passed on November 15, 2013, with bi-partisan support the Keep Your Health Plan Act of 2013. It would have permitted health insurance companies to continue to offer individual coverage that was in effect as of January 1, 2013, even if the policies did not meet ACA requirements. The administration threatened to veto the legislation had it reached the president's desk (which it did not), even though it would have codified a change made by the administration to permit states to allow insurers to renew non-compliant plans.[12]

Legislation which was enacted to provide statutory authority to changing the law

The administration has claimed it made the changes through regulation because Congress refused to consider legislative fixes. But the record proves that wrong. At least 17 changes to the law have been passed by both houses of Congress and signed into law by President Obama. Here are three examples:

- *CLASS Act repeal.* After extensive study, the Department of Health and Human Services concluded that the Community Living Assistance Services and Supports (CLASS) Act could not be self-sustaining as required by law. The CLASS Act was repealed on January 2, 2013.[13] (The legislation called for creation of a Long-Term Care Commission, on which I served, that developed an extensive and impressive list of reform recommendations for Congress. Our report was issued on September 30 of that year.[14])

- *1099 repeal.* On April 14, 2011, Congress repealed the controversial 1099 reporting provision that would have required businesses to report (on IRS Form 1099) whenever they pay a vendor more than $600 for goods in a single year.[15]

- *Medicaid fix.* Couples earning as much as $64,000 a year would have been able to qualify for Medicaid because of definitions of income calculations in the ACA. Congress saved taxpayers at least $13 billion when it amended this provision on November 21, 2011.[16]

More changes revealed

We continue to discover new evidence that the administration is not following the statute in its implementation of the law. The latest example was uncovered by Prof. Andy Grewal of the University of Iowa College of Law.[17] [18]

Coverage for some people under 100% FPL and for unlawful immigrants: The ACA provides tax credits to U.S. citizens with incomes between 100 and 400% of poverty, but IRS rules expanded the eligibility to extend the credits to citizens below 100% FPL in some cases.[19]

Also, Section 36B of the ACA grants credits to some non-citizens with low-incomes only if they are themselves lawfully present in the U.S. and cannot obtain Medicaid coverage. However, IRS regulations contradict the statute and allow subsidies if "the taxpayer *or a member of the taxpayer's family* is lawfully present in the United States." and "the lawfully present taxpayer *or family member* is not eligible for the Medicaid program."[20]

Health reform was needed, and people have received coverage

Our health sector definitely needed reform, especially to expand coverage to millions of people who had been shut out of insurance in the past. The Affordable Care Act has extended health insurance coverage to many people who needed insurance but could not afford it or obtain it because of pre-existing conditions. There was bi-partisan support in Congress when bills were being debated to achieve these goals, but instead of pursuing a bi-partisan solution, the Affordable Care Act was pushed through on a strictly partisan basis with unusual parliamentary maneuvers. This process did not leave Congress the usual ability to fix problems with the language in the Senate bill in conference.

The 50 changes already made to the law show that the law would have been difficult if not impossible to implement as it was written and passed. However, it is not the job of the administration to fix the law but to implement it as written. The U.S. Constitution requires the executive branch to seek new legislation, as it has done at least 17 times with the ACA, if changes to the law are needed. I would oppose these illegal administration actions no matter who was in the White House because they undermine the rule of law.

Companies inside and outside the health sector have spent countless billions of dollars trying to comply with the ACA. When the administration makes what some call "minor temporary course corrections," it causes a new cascade of disruption and expenses for companies and makes it even harder for them to comply not only with the law but with ever-changing regulations.

We have a process by which laws are to be enacted and changed, and that process has not been followed in implementing key provisions of the Affordable Care Act, as I have described here. I thank the committee for holding this hearing today to shed light on this issue. If our constitutional system of government is to survive, it must be based upon the rule of law.

ENDNOTES

[1] Grace-Marie Turner, "Fifty Changes to ObamaCare...So Far." Galen Institute, May 18, 2015. www.galen.org/newsletters/changes-to-obamacare-so-far/

[2] Internal Revenue Service, "Transition Relief for 2014 Under §§ 6055 (Information Reporting), 6056 (Information Reporting) and 4980H (Employer Shared Responsibility Provisions)," Notice 2013-45, July 9, 2013, http://www.irs.gov/pub/irs-drop/n-13-45.PDF.

[3] Federal Register 42159, http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf
[4] Anna Gorman, "For Many Middle-Class Taxpayers On Obamacare, It's Payback Time," February 26, 2015. Kaiser Health News. http://kaiserhealthnews.org/news/for-many-middle-class-taxpayers-on-obamacare-its-payback-time/
[5] Government Accountability Office, "Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings." GAO-12-409R: Published: March 21, 2012. Publicly Released: April 23, 2012. http://www.gao.gov/products/GAO-12-409R
[6] Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Insurance Standards Bulletin Series - Extension of Transitional Policy through October 1, 2016." March 5, 2014. http://www.cms.gov/CCIIO/ Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.
[7] Congressional Research Service, "Implementing the Affordable Care Act: Delays, Extensions, and Other Actions Taken by the Administration." March 3, 2015. http://fas.org/sgp/crs/misc/R43474.pdf
[8] CCIIO, CMS, HHS, "Loan program helps support customer-driven non-profit health insurance," December 22, 2014. http://www.cms.gov//CCIIO/Resources/Grants/new-loan-program.html
[9] Philip Klein, "Treasury Won't Explain Decision To Make $3 Billion in ObamaCare Payments," February 26, 2015. Washington Examiner. http://www.washingtonexaminer.com/treasury-wont-explain-decision-to-make-3-billion-in-obamacare-payments/article/2560739
[10] http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf
[11] Authority for Mandate Delay Act passed the House 264-161 on July 17, 2013, H.R. 2667. It would have codified the administration's announcement delaying the employer mandate and reporting requirements. Similarly, the House passed on that same date the Fairness for American Families Act 2S10174 H.R. 2668 that would have delayed enforcement of the individual mandate by a year. Both died in the Senate.
[12] Keep Your Health Plan Act of 2013 passed the House 261-157 on November 15, 2013. It would have codified the administration's action allowing continuation of non-compliant health plans beyond the statutory deadline.
[13] Congressional Research Service, "Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act," March 2, 2015. https://www.fas.org/sgp/crs/misc/R43289.pdf
[14] Commission on Long-Term Care. "Report to Congress." September 30, 2013. http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf
[15] Congressional Research Service, "Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act," March 2, 2015. https://www.fas.org/sgp/crs/misc/R43289.pdf
[16] *Ibid*
[17] Andy S. Grewal, "Lurking Challenges to the ACA Tax Credit Regulations." May 2015. Publication pending. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2598317
[18] Andy S. Grewal, "Another 'Glitch' with the ACA Tax Credit?" March 30, 2015. Yale Journal on Regulation. http://www.yalejreg.com/blog/another-glitch-with-the-aca-tax-credit-by-andy-grewal
[19] Federal Register /Vol. 76, No. 159 /Wednesday, August 17, 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf
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Fifty Changes to ObamaCare...So Far

Grace-Marie Turner
May 18, 2015

For updates to this list visit: www.galen.org/newsletters/changes-to-obamacare-so-far/

By our count at the Galen Institute, more than 50 significant changes have been made to the Patient Protection and Affordable Care Act, at least 31 that the Obama administration has made unilaterally, 17 that Congress has passed and the president has signed, and two by the Supreme Court.

CHANGES BY ADMINISTRATIVE ACTION

1. *Employee reporting*: The IRS announced that, contrary to statutory language, it was delaying the ACA requirement that employers must report to their employees on their W-2 forms the full cost of their employer-provided health insurance. (March 29, 2011)

2. *Medicare Advantage patch*: The administration ordered an advance draw on funds from a Medicare bonus program to provide payments to Medicare Advantage plans to temporarily forestall payment cuts called for in the ACA that could have led to cuts in benefits and an early exodus of MA plans from Medicare. (April 19, 2011)

3. *Coverage for some people under 100% FPL and for unlawful immigrants*: The ACA provides tax credits to U.S. citizens with incomes between 100 and 400% of poverty, but IRS regulations extend credits to citizens below 100% FPL in some cases. Also, Section 36B of the ACA grants credits to some non-citizens with low-incomes only if they are themselves lawfully present in the U.S. and cannot obtain Medicaid coverage. IRS regulations contradict the statute and allow subsidies if "the taxpayer *or a member of the taxpayer's family* is lawfully present in the United States," and "the lawfully present taxpayer *or family member* is not eligible for the Medicaid program." (August 17, 2011)

4. *Subsidies may flow through federal exchanges*: The IRS issued a rule that allows premium assistance tax credits to be available in federal exchanges although the law specified that they only would be available through an "Exchange established by the State." (May 23, 2012)

5. *Delaying a low-income plan*: The administration delayed implementation of the Basic Health Program until 2015. It would have provided more-affordable health coverage for certain low-income individuals not eligible for Medicaid. (February 7, 2013)

6. *Closing the high-risk pool*: The administration decided to prematurely halt enrollment in transitional federal high-risk pools created by the law, blocking coverage for an estimated 40,000 new applicants, citing a lack of funds. The administration had money from a fund under HHS Secretary Sebelius's control to extend the pools, but instead used the money to pay for advertising for Obamacare enrollment and other purposes. (February 15, 2013)

7. *Doubling allowed deductibles*: Because some group health plans use more than one benefits administrator, plans were allowed to apply separate patient cost-sharing limits to different services, such as doctor/hospital and prescription drugs, allowing maximum out-of-pocket costs to be twice as high as the law intended. (February 20, 2013)

8. *Small businesses on hold*: The administration said federal exchanges for small businesses will not be ready by the 2014 statutory deadline, and instead delayed until 2015 the provision of SHOP (Small-Employer Health Option Program) that requires exchanges to offer a choice of qualified health plans. (March 11, 2013)

9. *Employer-mandate delay*: By an administrative action that is contrary to language of the ACA, enforcement and reporting requirements for the employer mandate were delayed by one year until 2015. (July 2, 2013)

10. *Self-attestation*: Because of the difficulty of verifying income after the employer-reporting requirement was delayed, the administration it would allow "self-attestation" of income and eligibility by applicants for health insurance in the exchanges. (July 15, 2013)

11. *Congressional opt-out*: The administration decided to offer employer contributions to Members of Congress and their staffs when they purchase insurance on the exchanges created by the ACA, a subsidy the law doesn't provide. (September 30, 2013)

12. *Delaying the individual mandate*: The administration changed the deadline for the individual mandate by declaring that customers who purchased health insurance by March 31, 2014, would avoid the tax penalty. The law says they would have had to purchase a plan by mid-February to avoid penalties. (October 23, 2013)

13. *Insurance companies may offer canceled plans*: The administration announced that insurance companies may reoffer plans that previous regulations had forced them to cancel. (November 14, 2013)

14. *Delaying the online SHOP exchange:* The administration first delayed for a month and later for a year until November 2014 the launch of the online insurance marketplace for small businesses that originally was scheduled to launch on October 1, 2013. (September 26, 2013) (November 27, 2013)

15. *Exempting unions from reinsurance fee*: The administration gave unions an exemption from the reinsurance fee. To make up for this exemption, non-exempt plans will have to pay a higher fee, which will likely be passed onto consumers in the form of higher premiums and deductibles. (December 2, 2013)

16. *Extending Preexisting Condition Insurance Plan*: The administration extended the federal high risk pool until January 31, 2014 and again until March 15, 2014 to prevent a coverage gap for the most vulnerable. The plans were scheduled to expire on December 31, but were extended because it has been impossible for some to sign up for new coverage on healthcare.gov. (December 12, 2013) (January 14, 2014)

17. *Expanding hardship waiver to those with canceled plans:* The administration expanded the hardship waiver – which exempts people from the individual mandate and allows some to purchase catastrophic health insurance – to people who have had their plans canceled because of ObamaCare regulations. The administration later extended this waiver until October 1, 2016. (December 19, 2013) (March 5, 2014)

18. *Bay State bailout*: More than 300,000 people in Massachusetts gained temporary Medicaid coverage in 2014 without verification of eligibility, with the Obama and Patrick administrations using a taxpayer-funded bailout to mask the failure of the commonwealth's disastrously malfunctioning website. (January 2014)

19. *Equal employer coverage delayed:* Tax officials will not be enforcing in 2014 the mandate requiring employers to offer equal coverage to all their employees. This provision of the law was supposed to go into effect in 2010, but IRS officials have "yet to issue regulations for employers to follow." (January 18, 2013)

20. *Employer-mandate delayed again:* The administration delayed for an additional year provisions of the employer mandate, postponing enforcement of the requirement for medium-size employers until 2016 and relaxing some requirements for larger employers. Businesses with 100 or more employees must offer coverage to 70% of their full-time employees in 2015 and 95% in 2016 and beyond. (February 10, 2014)

21. *Extending subsidies to non-exchange plans*: The administration released a bulletin through CMS extending subsidies to individuals who purchased health insurance plans outside of the federal or state exchanges. The bulletin also requires retroactive coverage and subsidies for individuals from the date they applied on the marketplace rather than the date they actually enrolled in a plan. (February 27, 2014)

22. *Non-compliant health plans get two year extension*: The administration pushed forward by two years the deadline requiring health insurers to cancel plans that are not compliant with ACA mandates. These "illegal" plans can be offered until 2017. This extension prevented a wave of cancellation notices from going out before the 2014 midterm elections. (March 5, 2014)

23. *Reducing cost sharing reductions.* The ACA calls for out-of-pocket maximums to be lowered for enrollees with incomes between 100-400% FPL (Sec. 1402), but the provision proved unworkable for those 250-400% of FPL in combination with prescribed actuarial value requirements. The law was changed through regulation to apply to only those 100-250% of poverty. (March 11, 2014)

24. *Delaying the sign-up deadline:* The administration delayed until mid-April the March 31 deadline to sign up for insurance without penalty. Applicants simply need to check a box on their application to qualify for this extended sign-up period. (March 26, 2014)

25. *Canceling Medicare Advantage cuts:* The administration canceled further scheduled cuts to Medicare Advantage. The ACA calls for $200 billion in cuts to Medicare Advantage over 10 years. (April 7, 2014)

26. *More Funds for Insurer Bailout:* The administration said it will supplement risk corridor payments to health insurance plans with "other sources of funding" if the higher risk profile of enrollees means the plans would lose money. (May 16, 2014)

27. *Exempting U.S. territories:* Despite earlier administration claims that "HHS is not authorized to choose which provisions [of the ACA] might apply to the territories," HHS waived six major requirements – such as guaranteed issue, community rating, and essential benefit mandates – that were causing serious disruption to health insurance markets covering 4.5 million residents of U.S. territories. (July 18, 2014)

28. *Failure to enforce abortion restrictions.* A GAO report found that many exchange insurance plans don't separate charges for abortion services as required by the ACA, showing the administration is not enforcing the law. In 2014, abortions were being financed with taxpayer funds in more than 1,000 exchange plans. (Sept. 16, 2014)

29. *Risk Corridor coverage:* The Obama administration plans to illegally distribute risk corridor payments to insurers, despite studies by both the Congressional Research Service and the GAO saying a congressional appropriation is required before federal agencies can make the payments. (Sept. 30, 2014)

30. *Transparency of coverage:* CMS delays statutory requirements on insurance companies to disclose data on the number of people enrolled, disenrollment, number of claims denied, costs to consumers of certain services, etc. (Oct. 20, 2014)

31. *Tax penalty pass:* Taxpayers who filed returns based upon inaccurate subsidy data they received from the federal government will not have to repay the government if they received too large of a subsidy, the IRS ruled. (February 24, 2015)

CHANGES BY CONGRESS, SIGNED BY PRESIDENT OBAMA:

32. *Military benefits*: Congress clarified that plans provided by TRICARE, the military's health-insurance program, constitutes minimal essential health-care coverage as required by the ACA; its benefits and plans wouldn't normally meet ACA requirements. (April 26, 2010)

33. *VA benefits*: Congress also clarified that health care provided by the Department of Veterans Affairs constitutes minimum essential health-care coverage as required by the ACA. (May 27, 2010)

34. *Drug-price clarification*: Congress modified the definition of average manufacturer price (AMP) to include inhalation, infusion, implanted, or injectable drugs that are not generally dispensed through a retail pharmacy. (August 10, 2010)

35. *Doc-fix tax*: Congress modified the amount of premium tax credits that individuals would have to repay if they are over-allotted, an action designed to help offset the costs of the postponement of cuts in Medicare physician payments called for in the ACA. (December 15, 2010)

36. *Extending the adoption credit*: Congress extended the nonrefundable adoption tax credit, which happened to be included in the ACA, through tax year 2012. (Dec. 17, 2010)

37. *TRICARE for adult children*: Congress extended TRICARE coverage to dependent adult children up to age 26 when it had previously only covered those up to the age of 21 — though beneficiaries still have to pay premiums for them. (January 7, 2011)

38. *1099 repealed*: Congress repealed the paperwork ("1099") mandate that would have required businesses to report to the IRS all of their transactions with vendors totaling $600 or more in a year. (April 14, 2011)

39. *No free-choice vouchers*: Congress repealed a program, supported by Senator Ron Wyden (D., Ore.) that would have allowed "free-choice vouchers," that *The Hill* warned "could lead young, healthy workers to opt out" of their employer plans, "driving up costs for everybody else." The same law barred additional funds for the IRS to hire new agents to enforce the health-care law. (April 15, 2011)

40. *No Medicaid for well-to-do seniors*: Congress saved taxpayers $13 billion by changing how the eligibility for certain programs is calculated under Obamacare. Without the change, a couple earning as much as much as $64,000 a year would have been able to qualify for Medicaid. (November 21, 2011)

41. *CO-OPs, IPAB, IRS defunded*: Congress made cuts in funding to programs and agencies implementing the ACA including the IRS, and the controversial Independent Payment Advisory Board. (December 23, 2011; March 26, 2013)

42. *Slush-fund savings*: Congress cut $6.25 billion from the Prevention and Public Health slush fund through 2021, and $2 billion each year thereafter. (February 22, 2012)

43. *Less cash for Louisiana*: One of the tricks used to get Obamacare through the Senate was the special "Louisiana Purchase" deal to win the vote of then-Sen. Mary Landrieu. Congress saved taxpayers $2.5 billion by rescinding some funds from this deal. (February 22, 2012)

44. *CLASS Act eliminated*: Congress repealed the unsustainable CLASS (Community Living Assistance Services and Supports) program of government-subsidized long-term-care insurance, which Sen. Kent Conrad (D-ND) dubbed a "Ponzi scheme of the first order." (January 2, 2013)

45. *Defunding CO-OPs*: Congress cut an additional $2.2 billion from the "Consumer Operated and Oriented Plan" (CO-OP), which some saw as a stealth public option, blocking creation of new government-subsidized co-op programs. Early reports showed many co-ops, which had received federal loans, had run into serious financial trouble. (January 2, 2013)

46. *Trimming the Medicare trust-fund transfer*: Congress rescinded $200 million of the $500 million transfer from the Medicare Part A and Part B trust funds for the 5 year Community-Based Care Transition Program and rescinded $10 million of IPAB's FY2013 appropriation. (March 26, 2013)

47. *Eliminating caps on deductibles for small group plans*: Congress eliminated the cap on deductibles for small group plans as part of the SGR "doc fix." This gives small businesses the freedom to offer high deductible plans that may be paired with a Health Savings Account. (April 1, 2014)

48. *Making the risk corridor program budget neutral* The Consolidated and Further Continuing Appropriations Act of 2015 provides that CMS may not transfer funds from other accounts to pay for the risk corridor program. Expenditures cannot exceed the funds collected in 2014, blocking CMS from making multi-year calculations. (December 16, 2014)

CHANGES BY THE SUPREME COURT

49. *Medicare expansion made voluntary*: The court ruled it was voluntary, rather than mandatory, for states to expand Medicaid eligibility to people with incomes up to 138% of poverty by ruling the federal government couldn't block funds for existing state Medicaid programs if states chose not to expand the program. (June 28, 2012)

50. *The individual mandate made a tax*: The court determined that violating the mandate that Americans must purchase government-approved health insurance would only result in individuals' paying a "tax," making it, legally speaking, optional for people to comply. (June 28, 2012)

Chairman ROSKAM. Thank you, Ms. Turner.
Professor Adler.

STATEMENT OF JONATHAN H. ADLER, JOHAN VERHEIJ MEMORIAL PROFESSOR OF LAW, AND DIRECTOR, CENTER FOR BUSINESS LAW AND REGULATION, CASE WESTERN RESERVE UNIVERSITY SCHOOL OF LAW

Mr. ADLER. Thank you, Mr. Chairman, Ranking Member Lewis, and Members of this Subcommittee. I thank you for the invitation to testify today on how Federal agencies have been implementing the Affordable Care Act.

As you know, I have serious concerns about the way in which various agencies within the Department of Treasury and the Department of Health and Human Services have been implementing this law. In my view, they have repeatedly disregarded the plain text of the Affordable Care Act and the limits on their statutory authority.

Whatever the policy merits of the specific administrative actions they have taken, there are serious questions about their lawfulness, and these questions should certainly concern Members of this Committee, whatever your views of the policy merits of the ACA.

The core structure of our Constitution divides power among the three branches of our Federal Government. All legislative powers granted in the Constitution are vested in Congress. Executive agencies only have that authority which Congress has delegated to them. They have no inherent legislative authority, and they are bound by the President's constitutional obligation to take care that the laws are faithfully executed.

While the executive branch maintains the discretion over how the laws are to be enforced, such discretion does not entitle administrative agencies to disregard statutory provisions that are deemed unwise or inconvenient, let alone the authority to waive legal obligations that are written into Federal law.

The constable's authority to decide not to arrest every lawbreaker is not the authority to waive the law's obligations, and the agency's authority to allocate resources in accord with the executive branch's policy priorities does not allow it to disregard unwanted statutory mandates.

In the context of ACA implementation, Federal agencies have repeatedly failed to uphold the law as it was enacted by Congress. There are numerous instances in which Federal agencies have sought to waive relevant ACA requirements or implement the law in a manner that does not conform to the relevant statutory text and the authority that Congress granted.

Take but one example: Employers that fail to provide adequate health insurance under the law are subject to what the Administration deems is a tax. The ACA provides that this tax obligation shall apply to months beginning after December 31, 2013. There is nothing ambiguous about this language.

While the Administration has discretion over how vigorously to enforce this requirement and whether, for example, to seek penalties for noncompliance, it has no authority to waive the underlying liability, let alone to create subcategories among those em-

ployers subject to the requirement and tax liability. Yet, that is what the Administration has sought to do.

The Administration cited no meaningful legal authority for this decision. Treasury cited a series of past administrative actions. Yet, none of these are remotely comparable. For example, declining to seek penalties for noncompliance with certain tax laws is not the same thing as waiving a tax liability altogether when that tax liability accrues by operation of law at a date certain.

Unfortunately, this is not an isolated occurrence. The Administration has repeatedly disregarded statutory limits on its authority and cast aside the relevant statutory text in administering the ACA.

Other examples include an attempt to waive the minimum coverage requirement after it was made plain that the ACA would not allow individuals who liked their insurance plans to keep them; an IRS rule that purports to authorize tax credits in exchanges established by the Department of Health and Human Services, even though the ACA only authorizes tax credits in exchanges established by the States; IRS regulations extending tax-credit eligibility to some low-income aliens not lawfully residing in the United States as well as to some individuals who fall outside the income requirements explicitly established by the text of the Act; and the Department of Treasury's decision to issue cost-sharing subsidy payments to health insurance companies when Congress has failed to make appropriations in the support of such payments.

Even legal commentators who have been generally supportive of the Administration's implementation of the ACA and the underlying Act have raised serious questions about agencies' legal authority to take some of these steps.

University of Michigan Law Professor Nicholas Bagley, for example, wrote in the *New England Journal of Medicine* that several of these actions "appear to exceed the scope of the executive's traditional enforcement discretion," and cannot be justified as an exercise of executive branch authority to prioritize limited agency resources.

At stake is more than the implementation of this particular law. Professor Bagley put it well; so, I will quote him again. He said, "The Obama Administration's claim of enforcement discretion, if accepted, would limit Congress' ability to specify when and under what circumstances its laws should take effect. That circumscription of legislative authority would mark a major shift of constitutional power away from Congress, which makes the laws, and towards the President, who is supposed to enforce them."

There may well be good policy justifications for many of the measures I have discussed above. I offer no opinion in this testimony as to the policy wisdom of various steps Treasury and HHS have taken. My focus is, instead, on the lack of legal authorization for these actions. Whatever steps are taken to implement the ACA, whether by this Administration or its successors, they must conform to the law.

Administrative agencies have no warrant to rewrite statutes or waive statutorily imposed obligations, no matter how compelling the policy arguments in support of such changes may be. The ACA was controversial when it was enacted, and many provisions of the

law remain controversial today. If they are to be amended, it is the job of this Congress, not the job of administrative agencies.

Mr. Chairman and Members of this Subcommittee, I recognize the importance of these issues, and I am certainly willing to answer any questions you may have. Thank you again.

[The prepared statement of Mr. Adler follows:]

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Testimony of Jonathan H. Adler
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Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act

Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives

May 20, 2015

Mr. Chairman and members of this subcommittee, thank you for the opportunity to present testimony on how federal agencies have been implementing the Affordable Care Act (ACA).

My name is Jonathan H. Adler and I am the inaugural Johan Verheij Memorial Professor of Law and Director of the Center for Business Law and Regulation at the Case Western Reserve University School of Law, where I teach courses on administrative and constitutional law, among other subjects. I have written extensively on questions of administrative law generally, as well as on the implementation of the ACA.

As you know, I have serious concerns with the how the ACA has been implemented. In particular, I am concerned that the Departments of Treasury and Health and Human Services (HHS)have repeatedly disregarded the plain text of the ACA and the limits on their statutory authority when implementing this law. Whatever the policy merits of specific administrative actions, insofar as any federal agency has taken administrative actions that contradict the plain statutory text or exceed the scope of authority delegated by Congress they are unlawful.

The core structure of our Constitution divides power among the three branches of our federal government. "All legislative powers" granted in the Constitution are "vested" in Congress.[1] Federal agencies, while generally a part of the executive branch, are creatures of the legislature in that they only have that authority which Congress has delegated to them.[2] The executive branch has no inherent legislative authority, and executive agencies are responsible to the President, who has a constitutional obligation to "take Care that the Laws be faithfully executed."[3]

While the executive branch maintains the discretion over how the laws are to be enforced, such discretion does not entitle administrative agencies to disregard statutory provisions that are deemed unwise or inconvenient, let alone the authority to waive legal obligations that are written into federal law. The constable's authority to decide not to arrest every lawbreaker is not the authority to waive the law's obligations. An agency's authority to allocate resources in accord with the executive branch's policy choices does not allow it to disregard unwanted statutory mandates. Thus, enforcement discretion cannot excuse an administrative agencies disregard of relevant statutory text or an attempt to waive statutory requirements.

In the context of ACA implementation, federal agencies have repeatedly failed to uphold the law as it was enacted by Congress. There are numerous instances in which federal agencies have sought to waive relevant ACA requirements or implement the law in a manner that does not conform to the relevant statutory text and authority granted by Congress. A few examples follow.

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[1] U.S. Const. art. I, § 1.

[2] *See, e.g.*, Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208 (1988).

[3] U.S. Const. art. II, § 3.

Employer Mandate Delays

The ACA imposes a "shared responsibility" requirement obligating employers with more than 50 employees to provide qualifying health insurance.[4] Employers who fail to comply with this "employer mandate" are required to pay a penalty or "tax" that can reach $2,000 per employee beyond the 30th employee (i.e. a firm with 50 employees would pay the penalty on 20).[5] This provision exposes larger employers to substantial penalties if they fail to offer qualifying health insurance to their employees. According to the federal government, the penalty for failing to comply with the employer mandate is a "tax."

Section 1513 of the ACA expressly provides that this mandate, and the accompanying tax liability, was to "apply to months beginning after December 31, 2013."[6] In other words, this provision of the law was due to take effect at the start of 2014. In July 2013, however, the Department of the Treasury announced in a blog post that it would delay the employer mandate by a year.[7] The stated reason for this delay was "the complexity of the requirements" imposed on employers and "the need for more time to implement them effectively."[8] Later that month the IRS published a guidance detailing the "transition relief" to be afforded employers from the employer mandate and associated information reporting requirements.[9]

Seven months later, in February 2014, Treasury Department announced further delays of and modifications to the employer mandate.[10] Specifically, Treasury declared that the mandate would be delayed until 2016 for firms with fewer than 100 employees. In addition, Treasury announced that firms with over 100 employees would only need to provide qualifying insurance to 70 percent of their full-time employees in 2015, and 95 percent of employees thereafter, in order to avoid the statutory penalties. The Administration not only waived the effective date for the employer mandate, it also invented a new set of staggered requirements for firms. Again, agency officials said their intent was to help employers adjust to the law's requirements, though some observers saw more political motivations.[11]

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[4] *See* 26 U.S.C. §4980H(a)-(c).

[5] *Id.*

[6] See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1513(d), 124 Stat. 119 (2010) ("The amendments made by this section shall apply to months beginning after December 31, 2013.").

[7] See Mark Mazur, "Continuing to Implement the ACA in a Careful, Thoughtful Manner," Treasury Notes, U.S. Department of the Treasury (July 2, 2013), http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx.

[8] *Id.*

[9] *See* Internal Revenue Service, Transition Relief for 2014 Under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions), NOT-129718-13 (July 9, 2013), http://www.irs.gov/pub/irs-drop/n-13-45.pdf.

[10] *See Shared Responsibility for Employers Regarding Health Coverage*, 79 Fed. Reg. 8544, 8574 (Feb. 12, 2014).

[11] *See, e.g.*, Juliet Eilperin & Amy Goldstein, *White House delays health insurance mandate for medium-size employers until 2016*, WASH. POST (Feb. 10, 2014), http://www.washingtonpost.com/national/health-science/white-house-delays-health-insurance-mandate-for-medium-sized-employers-until-2016/2014/02/10/ade6b344-9279-11e3-84e1-27626e5ef5fb_story.html ("By offering an unexpected grace period to businesses with between 50 and 99 employees, administration officials are hoping to defuse another potential controversy involving the 2010 health-care law").

In justifying these delays, the Treasury Department claimed that it has broad authority to offer "transition relief" in implementing a complex law like the ACA. That may often be true in other cases, but not here. When Congress provides that a given legal requirement takes effect on a date certain, that is when the legal requirement takes effect. If, as the Administration has claimed, the employer mandate penalty is a tax, that tax liability for non-complying employers began to accrue at the start of 2014. As Congress did not delegate the executive branch authority to waive or delay this requirement, there was no authority for these delays.

Whatever the stated reason for the two delays, nothing in the ACA authorizes the executive branch to waive the application of the employer mandate penalties. The text of the ACA is quite clear. It provides that the employer mandate provisions "shall apply" after a date certain: December 31, 2013.[12] Were this not enough, other provisions of the ACA reinforce the statutory requirement. For example, the ACA expressly provides for the amount of the employer penalty to be assessed in 2014, and then provides for the penalties to be adjusted for inflation in subsequent years.[13]

That Congress expected the employer mandate to take effect in 2014 is reaffirmed by the fact that implementation of this requirement is essential for the proper implementation of other parts of the law. For instance, the employer mandate reporting provisions are essential to determining eligibility for tax credits and cost-sharing subsidies in state health insurance exchanges. These tax credits were to be available beginning January 1, 2014 and serve as the trigger for assessing the penalty.[14] The tax credits and employer penalties were supposed to take effect together, and the Administration never suggested delaying the credits (though it did waive verification of eligibility).[15]

The Treasury Department claimed delaying the effective date of the employer mandate was an ordinary exercise of its "longstanding authority to grant transition relief when implementing new legislation."[16] Despite this claim, the Treasury Department failed to identify an applicable precedent that would justify waiving a tax liability prospectively as the Administration sought to do. Treasury cited cases in which the IRS waived potentially applicable penalties or allowed deferred payment of tax liabilities, but these are easily distinguishable. Further, if the mandate penalty is a tax — as the administration currently maintains in various ACA-related cases pending in federal court — then the employer mandate delay constitutes more than deferring

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[12] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1513(d), 124 Stat. 119 (2010) ("The amendments made by this section shall apply to months beginning after December 31, 2013.").

[13] *See* 26 U.S.C. §4980H(c)(5).

[14] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1401(e), 124 Stat. 119 (2010) ("The amendments made by this section shall apply to taxable years ending after December 31, 2013.").

[15] *See* Sarah Kliff & Sandhya Somashekhar, *Health insurance marketplaces will not be required to verify consumer claims*, WASH. POST (July 5, 2013), http://www.washingtonpost.com/national/health-science/health-insurance-marketplaces-will-not-be-required-to-verify-consumer-claims/2013/07/05/d2a171f4-e5ab-11e2-aef3-339619eab080_story.html.

[16] *See* Letter from Mark Mazur, Assistant Secretary of the Treasury for Tax Policy, to Rep. Fred Upton, Chairman of the Committee on Energy and Commerce, U.S. House of Representatives, July 9, 2013, http://democrats.energycommerce.house.gov/sites/default/files/documents/Upton-Treasury-ACA-2013-7-9.pdf.

payments or declining to seek penalties. Rather it constitutes a unilateral decision by the executive branch to waive an accrued tax liability.

Even legal commentators who have been generally supportive of this Administration's implementation of the ACA have acknowledged that the Treasury Department lacked the legal authority to delay employer mandate. University of Michigan law professor Nicholas Bagley, for instance, wrote in the *New England Journal of Medicine* that these delays "appear to exceed the scope of the executive's traditional enforcement discretion" and cannot be justified as an exercise of executive branch authority to prioritize limited agency resources.[17] As Bagley explains, the employer mandate delays cannot be justified as the sort "discretionary judgment[s] concerning the allocation of enforcement resources" approved by the Supreme Court in *Heckler v. Chaney*.[18] In his view, the purported precedents relied upon by Treasury provided "slim support for a sweeping objection that will relieve thousands of employers from a substantial tax for as long as 2 years."[19] I concur with this assessment.

The assertion of unilateral authority to delay the employer mandate – if ratified and accepted as a precedent for agency action in the future – could mark a dramatic shift in the separation of powers. As Bagley explains:

> the Obama Administration's claim of enforcement discretion, if accepted, would limit Congress's ability so specify when and under what circumstances its laws should take effect. That circumscription of legislative authority would mark a major shift of constitutional power away from Congress, which makes the laws, and toward the President, who is supposed to enforce them.[20]

At stake is more than a contested an unpopular provision of the ACA. This assertion of executive authority has far-reaching implications and should concern all members of this Committee, whatever one's view of the employer mandate or the ACA.

Minimum Coverage Requirement

The ACA imposes a suite of minimum coverage and other requirements on all private health insurance plans. Insurance plans that do not meet all of these requirements are non-compliant and, as a consequence are illegal under the ACA. The law contained a "grandfather" provision allowing the continuation of some such plans for a limited time, but this provision was relatively narrow, and interpreted by the Department of Health and Human Services to be even narrower.[21] Even though ACA supporters repeatedly promised that those Americans who liked their

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[17] *See* Nicholas Bagley, *The Legality of Delaying Key Elements of the ACA*, 370 NEW ENGL. J. MED. 1967, 1968 (2014).

[18] 470 U.S. 821 (1985).

[19] *Id.* at 1969.

[20] *Id.*

[21] *See* 45 C.F.R. § 147.140(g).

insurance plans would be able to keep them, the ACA, as written, ensured that many who liked their pre-existing health insurance plans would not be allowed to keep them.[22]

In 2013, many Americans learned that their existing health insurance plans would not be renewed for failing to meet the ACA's minimum coverage requirements and could not be renewed. Modest year-to-year changes in pre-existing plans resulted in the loss of "grandfather" status. In response, the Administration announced a fix.

On November 14, 2013, the Administration declared that insurance companies would be allowed to renew policies that were in force as of October 1, 2013 for one additional year, even if they failed to meet relevant ACA requirements.[23] This announcement was made initially in a Presidential press conference, and was subsequently reaffirmed in guidance documents issued by the Department of Health and Human Services.[24] As with the delays of the employer mandate, there was no clear legal authority for this change.[25] Indeed, no citation of legal authority accompanied the President's announcement or the subsequent letter from the Administration to state insurance commissioners encouraging them to allow the renewal of noncompliant plans.

As with the employer mandate, the relevant statutory provisions are clear. Under the ACA, only plans that provide the prescribed list of "essential benefits" can be "qualified health plans" (QHPs), and only QHPs may be sold on exchanges or satisfy the minimum coverage requirement (the individual mandate).[26] Further, the ACA bars insurers from offering health insurance plans in individual and small group markets that do not include the essential health benefits package.[27] These requirements cannot be waived by administrative fiat. A Presidential announcement cannot overcome the legal jeopardy health insurers could face should they agree to renew such plans and seek enforce any terms that have been declared illegal under the ACA and its implementing regulations.

The only legal justification the Administration offered for this move was "enforcement discretion." Specifically, the Administration claimed it was not changing the law so much as it was merely announcing that it would not enforce relevant requirements for a given period time. This legal justification does not work, however. Among other things, the Administration's announcement did not alter the underlying legal requirements contained in the ACA or its implementing regulations, nor did it bind state insurance commissions or affect state laws governing insurance policies.

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[22] The Department of Health and Human Services, for instance, predicted in June 2010, that that between 40 and 67 percent of individual market policies would lose grandfather status in any given year. See 75 Fed. Reg. 34,538, 34,553 (June 17, 2010); *see also* Colleen McCain Nelson, Peter Nicholas & Carol E. Lee, *Aides Debated Obama Health-Care Coverage Promise*, WALL ST. J. (Nov. 2, 2013).

[23] *See* Statement by the President on the Affordable Care Act (Nov. 14, 2013), http://www.whitehouse.gov/the-press-office/2013/11/14/statement-president-affordable-care-act.

[24] *See* Letter from Gary Cohen, Director, Ctr. for Consumer Info. & Ins. Oversight, Dept. of Health & Human Servs (Nov. 14, 2013), http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[25] *See* Bagley *supra*.

[26] *See* 42 U.S.C. § 18021(a); 26 U.S.C. § 5000A.

[27] *See* 42 U.S.C. § 300gg–6

Although the Administration claimed it was relying on enforcement discretion, the announced policy did more than pull back enforcement of the law's requirements. It also sought to impose new obligations on private insurers. Specifically the new policy conditioned the exercise of enforcement discretion on private insurers agreeing to a series of disclosures to those who might wish to renew their policies for an additional year. As detailed in a guidance letter explaining the change, insurers wishing to renew their policies would be required to provide their customers with a notice explaining that the relevant policies fail to comply with the ACA's requirements, that other more comprehensive policies are available, and how such policies may be obtained. Whether or not requiring such disclosure is a good idea, nothing in the ACA authorized the Administration to take this step. As with the employer mandate delay, these policy steps cannot be justified as an exercise of enforcement discretion.

Exchange Tax Credits

Among the most high-profile and controversial examples of an administrative agency implementing the ACA in an unlawful manner is the IRS rule purporting to authorize tax credits in health insurance exchanges established by the federal government.[28] Four lawsuits were filed against this rule. The challengers include individuals, employers, states, and local school boards that are adversely affected by the authorization of tax credits in federal exchanges. The Supreme Court heard oral argument in one of these cases, *King v. Burwell*, in March, and a decision is expected by the end of June.

Section 1311 of the ACA directs each state to create an "American Health Benefit Exchange" ("Exchange").[29] Despite the obligatory language of Section 1311, the ACA gives states a choice of whether to take responsibility for (and bear the cost of) operating its own Exchange. States that agreed to set up their own Exchange were eligible for start up funds from the federal government. Moreover, the ACA provides for tax credits and cost-sharing subsidies to assist low-income individuals with the purchase of qualifying health insurance on state-established exchanges.

As written, the ACA only provides tax credits and cost-sharing subsidies for the purchase of qualifying health insurance plans in exchanges that are "established by the State" under Section 1311 of the Act. Specifically, the ACA authorizes tax credits for each month in a given year in which a taxpayer has obtained qualifying health insurance. As defined by the law, a "coverage month" is any month in which the taxpayer is "covered by a qualified health plan . . . that was enrolled in through an Exchange established by the State under section 1311."[30] The amount of the tax credit is also calculated with reference to a qualifying health insurance plan "enrolled in through an Exchange established by the State under [Section] 1311."

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[28] For an extensive treatment of this issue, see Jonathan H. Adler & Michael F. Cannon, *Taxation without Representation: The Illegal IRS Rule to Expand Tax Credits under the ACA*, 23 HEALTH MATRIX: JOURNAL OF LAW-MEDICINE 119 (2013); *see also* Jonathan H. Adler & Michael F. Cannon, King v. Burwell: *Desperately Seeking Ambiguity in Clear Statutory Text*, 40 JOURNAL OF HEALTH, POLITICS, POLICY & LAW 577 (2015).

[29] *See* 42 U.S.C. §18031(b)(I).

[30] *See* 26 U.S.C. § 36B(c)(2)(A)(i).

If a state refuses to establish its own exchange, the federal government is required to "establish and operate" an exchange for that state.[31] While a federal exchange may operate like a state exchange, nothing in the ACA authorizes the provision of tax credits or cost-sharing subsidies in federal exchanges. To the contrary, as noted above, the relevant provisions of Section 1401 only provide for tax credits for the purchase of health insurance in state-established exchanges.

When the ACA was enacted, it was generally assumed that most if not all states would willingly create exchanges.[32] As President Obama explained shortly after signing the legislation into law, "by 2014, each state will set up what we're calling a health insurance exchange."[33] Few expected that many (if any) states would refuse. But states turned out to be far less cooperative than anticipated. Despite the Administration's best efforts to encourage state cooperation, some three dozen states refused to create their own exchanges.

Faced with the prospect that widespread state refusal to establish Exchanges under the ACA would make tax credits and cost-sharing subsidies unavailable in much of the country, the IRS promulgated regulations in May 2012 providing that tax credits would be available for the purchase of qualifying health insurance plans in states established under either Section 1311 *or* 1321, and without regard for whether the exchange was established by a state or established by the federal government.[34] To justify its decision, the IRS explained:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.[35]

Although commentators had argued that the express language of the ACA precluded the IRS interpretation, this paragraph – lacking any citation to relevant statutory provisions, legislative history, or other legal authority – was the entirety of the IRS's justification for the rule upon its promulgation.

The IRS did not identify any statutory language to justify its interpretation when it finalized the rule. There is a simple explanation for this: There isn't any. This is key because in the absence of

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[31] *See* 42 U.S.C. § 18041(c)(1).

[32] *See* Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, NY TIMES, Aug. 5, 2012 ("When Congress passed legislation to expand coverage two years ago, Mr. Obama and lawmakers assumed that every state would set up its own exchange").

[33] Barack Obama, U.S President, Remarks on Health Insurance Reform in Portland, Maine (Apr. 1, 2010), available at: http://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-portland-maine.

[34] Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 Federal Register 30377 (May 23, 2012), available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf.

[35] *Id.* at 30378.

such language, the IRS lacks the authority to extend tax credits where Congress has failed to do so.

Months later, under pressure from members of Congress to offer a more complete explanation, the Department of the Treasury began to identify potential authority for its rule. Specifically, the Treasury Department suggested that the language of Section 1321 could be interpreted to make a federally established exchange "the equivalent of a state exchange in all functional respects," including an Exchange for purposes of determining eligibility for tax credits.[36]

According to this later justification, an exchange established by the federal government under Section 1321 may be treated as an exchange established by the State under Section 1311. This is because HHS is required to "establish and operate *such Exchange* within the State."[37] "Such exchange," according to Treasury, is a Section 1311 Exchange and should be treated as such for the purposes of authorizing tax credits and cost-sharing subsidies. Concluding otherwise, Treasury maintained, would undermine the ACA's stated purpose of expanding health insurance coverage.

Treasury's interpretation would be a plausible interpretation of the relevant statutory text were it not for repeated references to the state role in establishing those Exchanges through which tax credits may be offered. As noted above, Section 1311 expressly requires that an authorized Exchange must be "established by a State." Section 1304(d) also expressly defines "state" as "each of the 50 States and the District of Columbia."[38] Yet even if one were to set this language aside, as the Treasury Department suggests, and conclude that a Section 1321 Exchange is the equivalent of a Section 1311 Exchange, this is not enough to establish that tax credits are available in exchanges established by the federal government.

The eligibility requirements for the tax credits are not found in either Section 1311 or Section 1321, but in Section 1401, which creates Section 36B of the Internal Revenue Code. This section repeatedly defines qualifying health insurance plans eligible for tax credits as those purchased "through an Exchange *established by the State*" under section 1311. So even if one reads Section 1321 to provide that an Exchange established by the federal government is, for all intents and purposes, a Section 1311 Exchange, a federal Exchange is still not an Exchange "established by the State" as required by Section 1401. Put another way, "such Exchange" may well be the same type of exchange called for under Section 1311, but an exchange established by the federal government is not an exchange "established by the State."

The repeated reference to the state role in creating the relevant exchanges is significant. Not all references to exchanges in the ACA reference the state role as Section 1401 does. Section 1421, for example, provides tax credits to small businesses that make nonelective contributions to employee plans offered through an Exchange. Yet whereas Section 1401 repeatedly references Exchanges "established by a State," Section 1421 only references "Exchanges." Under the

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[36] *See* Letter from Mark J. Mazur, Assistant Secretary for Tax Policy, U.S. Treasury Department, to the Honorable Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives, (Oct. 12, 2012) (on file with author).

[37] *See id.* (citing 42 U.S.C. §18041(c)(1).

[38] *See* 42 U.S.C. § 18024(d)

Treasury Department's interpretation, the additional language in Section 1401 is reduced to surplusage.

The Treasury Department claims that its interpretation merely reaffirms well-established Congressional intent. Yet neither the federal government – nor anyone else – has been able to identify a single contemporaneous statement indicating that tax credits would be available for the purchase of health insurance in federal exchanges under the ACA. The lack of any such statement is more than a bit conspicuous, especially since numerous health care reform proposals considered prior to enactment of the ACA conditioned subsidies on state cooperation.[39]

While the IRS claimed that "relevant" legislative history supports its interpretation, it has failed to identify a single statement prior to or contemporaneous with the passage of the ACA indicating that tax credits were to be available in federal exchanges. Contrary to the IRS's suggestion, the burden is not on opponents of its rule to identify legislative history or statutory language prohibiting the issuance of tax credits in federal exchanges. As the U.S. Court of Appeals for the D.C. Circuit has instructed federal agencies on numerous occasions, Congressional failure to withhold power does not indicate such power was delegated, nor does it constitute a statutory ambiguity of the sort that would trigger *Chevron* deference to the Agency's interpretation of the statute.[40] A failure to delegate authority to an agency is just that: A failure to delegate authority.

The IRS rule purports to provide tax credits in over thirty states that opted not to create their own exchanges. Because these are "refundable" tax credits, this means that the credits do more than provide tax relief to eligible individuals. They result in payments from the U.S. Treasury. Because the Administration has announced that it will not require exchanges to verify eligibility for tax credits, the cost could be significantly greater than many have anticipated. Issuance of the tax credits triggers cost-sharing subsidies that are paid to insurance companies – another draw on the U.S. Treasury. Tax credit eligibility also triggers substantial penalties on employers who fail to provide qualifying health insurance. The availability of tax credits will also expose many individuals to the individual mandate tax penalty who would not otherwise have been so exposed. As a consequence, this rule has substantial fiscal and legal consequences.

As noted above, the Supreme Court is expected to rule on the lawfulness of the IRS rule later this year in *King v. Burwell*. Should those challenging the rule prevail, it will be important to monitor how the Administration responds to an adverse ruling. While the IRS and HHS would have some administrative flexibility in developing a response to such a ruling, they would be somewhat constrained by the text of the ACA and the Court's specific holding.

However the Court rules in *King*, this rule is not the only example of the IRS taking liberties with the text of the ACA in implementing Section 36B of the Internal Revenue Code. Professor Andy Grewal of the University of Iowa School of Law has identified two additional instances of the IRS departing from the text of the statute in ways that expands tax credit eligibility beyond

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[39] *See* Adler & Cannon supra.

[40] *See, e.g.*, American Bar Association v. Federal Trade Commission, 430 F.3d 457 (D.C. Cir 2005); Railway Labor Executives Association v. National Mediation Board, 29 F.3d 655 (D.C. Cir. 1994).

what Congress has authorized.[41] Specifically, Grewal notes that IRS regulations implementing 36B in such a way as to extend tax credit eligibility to some low-income aliens not lawfully residing in the U.S. as well as to some individuals who fall outside the income requirements explicitly established by the text of the ACA. In neither case, Grewal notes, did the IRS cite any legal authority for its actions. Most likely this is because, in both instances, the IRS regulations contravene the express statutory text of the ACA.

These IRS rewrites have potential consequences beyond the extension of tax credits beyond what Congress authorized. As with the tax credit regulation at issue in *King v. Burwell*, the latter of these changes has the potential to expose employers to penalties that are not authorized by the text of the ACA. Again, by expanding eligibility for tax credits the IRS is also expanding employer exposure to the employer mandate and its associated penalties.

Cost-Sharing Subsidies

Not only has the Treasury Department purported to authorize tax credits beyond what was authorized by Congress under the ACA, it has also issued payments to health insurance companies under Section 1402 of the ACA where no money was appropriated by Congress. This is unconstitutional. As the Constitution makes clear, "[n]o Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law."[42] While it may be desirable for the federal government to provide money to health insurance companies to offset the costs of meeting various ACA requirements, neither Treasury nor HHS has the authority to make such payments unilaterally.

While the ACA authorizes the payment of subsidies to health insurance companies to help defray the costs of providing health insurance to eligible consumers, Congress has not appropriated the funds necessary to make these payments. Specifically, Section 1402 of the ACA requires insurers to make cost-sharing reductions that reduce the out-of-pocket costs of health insurance for eligible low-income individuals. Section 1402 also authorizes offset payments to health insurance companies to help defray the costs of making these cost-sharing reductions. Such authorization, however, is not the same as an appropriation. In order for an expenditure of taxpayer dollars to be lawful, spending authorization, such as that contained in Section 1402, must be followed by an actual appropriation, whether in the form of an annual appropriations bill (aka a "temporary appropriation") or a permanent appropriation such as those which fund entitlements, interest payments, and tax refunds, among other things.

That Congressional appropriations were necessary to fund payments to health insurance companies under Section 1402 was acknowledged by the Administration in the 2014 budget request. Congress did not appropriate these funds, however. As a consequence, there are no funds to be spent on payments to insurance companies under Section 1402. Nonetheless, the Treasury Department made nearly $4 billion in payments to health insurance companies. As I understand it, the Administration is instead relying upon the permanent appropriation which provides funds to the IRS for income tax refunds to make these payments, yet Congress has not

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[41] *See* Andy Grewal, *Lurking Challenges to the ACA Tax Credit Regulations*, BLOOMBERG BNA TAX INSIGHTS (2015 forthcoming) *available at*: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2598317.

[42] U.S. Const. art. 1 § 9.

authorized this step. In other words, the Treasury Department has, in conjunction with HHS, usurped the legislature's authority to control appropriations from the U.S. Treasury.

Conclusion

In my testimony, I have sought to briefly review a handful of instances in which federal agencies entrusted with implementing the ACA have departed from the statutory text and acted in an unlawful manner. I doubt these are isolated instances. Earlier this year, Ohio Attorney General Mike DeWine brought suit against HHS for its attempt to impose taxes on state and local government health insurance plans. Based on my initial review of the filings, I believe Ohio may have identified yet another example of unlawful ACA implementation.

There may well be good policy justifications for many of the measures discussed above. I offer no opinion in this testimony as to the policy wisdom of the various steps Treasury and HHS have taken. My focus has instead been on the lack of legal authorization for these actions. Whatever steps are taken to implement the ACA, whether by this Administration or its successors, they must conform to the law. Administrative agencies have no warrant to rewrite statutes or waive statutorily imposed obligations, no matter how compelling the policy arguments in support of such changes may be.

The ACA was controversial when it was enacted, and many provisions of this law remain controversial today. If they are to be amended, however, it is a job for the legislature. Only Congress has the authority to revise the ACA and cure its imperfections.

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Mister Chairman and members of this committee, I recognize the importance of these issues to you, your constituents, and this nation. I hope that my perspective has been helpful to you today, and I will seek to answer any additional questions you might have. Thank you.

Chairman ROSKAM. Thank you.
Ms. Papez.

STATEMENT OF ELIZABETH P. PAPEZ, PARTNER, WINSTON & STRAWN LLP, MEMBER, ADJUNCT FACULTY, GEORGE WASHINGTON UNIVERSITY LAW SCHOOL, FORMER DEPUTY ASSISTANT ATTORNEY GENERAL, OFFICE OF LEGAL COUNSEL, U.S. DEPARTMENT OF JUSTICE

Ms. PAPEZ. Thank you, Mr. Chairman, Ranking Member Lewis, and Members of the Subcommittee for the opportunity to appear here today and discuss the administrative efforts to implement the Affordable Care Act.

Agency implementation is obviously a necessary part of administering complex legislation, but it presents special challenges under the ACA because the law calls upon multiple agencies to implement an unusually elaborate and costly network of related Federal and State programs. The statute is 904 pages long and in over 700 instances directs Federal agencies to set the rules for an array of new government programs worth more than $1 trillion.

The testimony this morning has already addressed various policy and legal challenges surrounding some recent agency efforts to implement or, in certain cases, delay implementing some of these programs over the last 5 years. So I thought I would confine my remarks to a few constitutional and governance issues that I think transcend the debate over particular programs and underscore why agency administration of the ACA presents an especially strong case for ongoing legislative oversight by this Subcommittee and others.

As the Chairman noted, the governance issues date back to the founding, which recognize the hazards of concentrating power in a single person or a body. The U.S. Constitution answers this concern with a Federalist structure. It is often described as the essential basis for a free system of government. It divides authority among the three branches of the Federal Government and between the Federal Government and the States.

The so-called separation of powers issues that attend the ACA's administration reflect this constitutional division of authority and arise anytime statutes look to Federal agencies to define the scope of Federal programs. But these issues demand particular attention when its statute relies on agency implementation and discretion to the degree ACA does.

I had the privilege of working on some of these issues during my time at the Justice Department and, as a law clerk and, also, as a law firm partner, have seen how they can directly and significantly affect the private sector, in fact, in millions of people and trillions of dollars of Federal programs.

The separation of powers issues are already playing out in a number of government efforts to implement the statute today. The regulations implementing the employer coverage mandate categorically revise certain statutory compliance deadlines and employer participation requirements.

The Treasury Department's cost-sharing regulations conclude that, despite prior Administration requests for annual appropria-

tions, the subsidies actually may be paid from funds permanently appropriated for specific tax credits.

And IRS regulations declare that the premium tax-credit provision expressly directed at insurance exchanges created by a State must, nonetheless, be read to encompass exchanges established by Federal agencies.

The Administration has defended these challenged regulations as lawful efforts to implement the Act and as appropriate responses to perhaps unanticipated shortfalls in funding, State participation, and private sector readiness central to the Act's Affordable Care mandate.

In fact, Mr. Weiner's written testimony, I think, for this hearing points out that some of the regulatory actions now being challenged by this Subcommittee and in the courts were directly responsive to constituent input.

There are a couple of things I would say about that. The first is that political accountability is obviously important in our system of government, but the Constitution limits the extent to which agencies may interpret legislation to address such concerns or encompass new circumstances.

The second thing I would say is I am familiar with some of the examples of past executive branch action that the current Administration cites as precedent for its ACA administration efforts, and I frankly don't think they are comparable in scope or in statutory authorization to some of the ACA implementation issues we will discuss this morning, nor do I think Supreme Court decisions like Heckler v. Chaney are on point.

Those cases are about the executive branch's discretion to enforce the laws, not to pass by regulation wholesale exemptions from an existing statute. That is the kind of executive branch action that is equivalent to suspending a law and has long been considered an improper intrusion on Congress' authority.

The third thing and, I guess, the last thing I would say is, to the extent that some of these past examples of executive branch action are comparable to the current administrative efforts to implement the ACA, they simply illustrate the broader point that adherence to separation of powers principles is not a partisan issue.

As I think even Mr. Weiner's examples in his written statement indicate, they are issues that cut across policies at Administrations, which is why their resolution in the healthcare context is incredibly important, because it could have consequences for future governments and programs that have nothing to do with health care.

As these issues unfold in the ACA context and otherwise, I think this Subcommittee's continued exercise of its oversight authority will be critical to ensuring implementation of the Act and all of its provisions consistent with the separation of powers and Federalism limits the Constitution requires.

Thank you for the opportunity to testify today.

[The prepared statement of Ms. Papez follows:]

STATEMENT OF ELIZABETH P. PAPEZ[1]

FORMER DEPUTY ASSISTANT ATTORNEY GENERAL
OFFICE OF LEGAL COUNSEL
U.S. DEPARTMENT OF JUSTICE

BEFORE THE

COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON OVERSIGHT
UNITED STATES HOUSE OF REPRESENTATIVES

EXAMINING THE USE OF ADMINISTRATIVE ACTIONS IN THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

MAY 20, 2015

Thank you Chairman Roskam, Ranking Member Lewis, and Members of the Subcommittee. I appreciate the opportunity to appear here today to discuss the use of administrative actions to implement the Affordable Care Act (ACA or Act). Agency implementation is an inescapable part of administering complex legislation. And it presents special challenges under the ACA because the law calls upon multiple agencies to implement an especially elaborate and costly network of related federal and state programs. Because of their price and practical burdens, many of these programs have been the subject of staggered agency implementation since the Act's passage in March 2010. Much has been said about the policy and legal issues surrounding these implementing efforts. What I would like to address briefly this morning are certain constitutional and governance issues that transcend the debate over particular programs. These issues are not academic. They have real consequences for the millions of people and trillions of dollars affected by the ACA's administrative implementation.

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And their resolution in the ACA context requires careful consideration because it could have important consequences for future governments and programs that have nothing to do with healthcare.

The constitutional questions that surround recent administrative efforts to implement the ACA reflect the separation of powers among the three federal branches of government as well as the division of sovereign authority between the federal government and the States. As relevant here, Article I commits to Congress the powers to legislate, tax, appropriate funds, and regulate interstate commerce consistent with state sovereignty. Article II empowers the Executive Branch to interpret and enforce legislation with due regard for the authorities reserved to Congress, the judiciary and the States. And Article III empowers federal courts to interpret statutes and review the legality of agency action in justiciable cases.

Each branch has an independent duty to exercise its constitutional authority within the bounds of this framework, and failure to do so can have a ripple effect that threatens the rule of law across administrations and programs. Recent efforts to implement the ACA illustrate this risk. The statute's provisions on employer coverage, cost-sharing subsidies, and premium tax credits present economic and practical challenges that have prompted implementing agencies to range beyond the Act's text to an extent that has spurred constitutional challenges from coordinate branches and regulated individuals. The employer coverage regulations categorically revise express statutory compliance deadlines and participation requirements. The Treasury Department's cost-sharing regulations conclude that, despite the administration's prior requests for annual appropriations, cost-sharing subsidies may be paid from funds permanently appropriated for specific tax credits. And IRS regulations declare that the premium tax credit provision expressly directed at insurance exchanges "created by a State" must also encompasses

exchanges established by federal agencies. The Executive Branch defends these actions as lawful efforts to implement the Act, and as appropriate responses to apparently unanticipated shortfalls in funding, state participation, and private sector readiness central to the Act's affordable care mandate. But the Constitution limits the extent to which agencies may interpret legislation to encompass or address evolving circumstances. Accordingly, this Subcommittee recently questioned whether the administration's employer coverage and cost sharing regulations exceed constitutional limits and intrude upon Congress's legislative and appropriations authority. Parallel challenges to agency implementation of the Act's cost-sharing and premium tax credit provisions have also made their way into two pending lawsuits. Regardless of their outcome, these suits and the ongoing disagreement between the political branches regarding ACA's implementation highlight the constitutional obligations and risks that attend administration of complex legislation, and underscore the need for continuing legislative oversight.

I. Employer Coverage Regulations.

Section 1513 of the Act requires certain employers to offer all full-time employees statutorily-prescribed insurance coverage by 2014 or face tax penalties established in the tax code provisions the Act amends.[2] Notwithstanding the statute's express coverage requirements and compliance deadline, the Treasury Department announced both in press releases and a formal rulemaking that the Act's 2014 requirements and penalties would not apply until 2016.[3] Specifically, the regulations depart from the Act's 2014 mandates by waiving statutory penalties for employers who cover at least 70 percent of relevant employees in 2015, and by waiving such for employers who cover at least 95 percent of relevant employees in 2016.

[2] 43 U.S.C. §§ 4980H(a)-(b).

[3] 79 Fed. Reg. 8544 (Feb. 12, 2014).

These regulations raise fundamental questions about when agency action crosses the constitutional line that separates implementation from legislation. Executive Branch agencies may interpret and enforce federal statutes, but may not rewrite or amend them. The line between administration and revision is sometimes blurry, but historical definitions of inherently legislative acts are instructive. The definition of a legislative act as defining the boundaries of permissible conduct at a particular point in time dates back to Locke, who explained that the legislative authority "cannot assume to its self a power to Rule by extemporary Arbitrary Decrees," but is rather bound to promulgate "standing Laws," by which "every one may know what is his."[4] Under this definition and the U.S. Constitution, administrative actions that make categorical changes to express statutory prescriptions threaten the line that separates implementation from legislation. The Executive Branch's prosecutorial discretion to decide where to spend its limited resources, and to decline prosecution of conduct a statute makes punishable, does not empower agencies to exempt entire classes of people or conduct from express statutory prohibitions or time limits. That is because such acts are equivalent to suspending portions of a statute, which is a power Article I reserves to Congress in keeping with its historical treatment as a quintessentially legislative function.[5]

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[4] JOHN LOCKE, THE SECOND TREATISE ON GOVERNMENT, para. 136, *in* TWO TREATISES OF GOVERNMENT 358-59 (Peter Laslett ed., 1988) (1689).

[5] "In the seventeenth century . . . royal suspensions and dispensations became a source of acute conflict between Parliament and the Crown." Zachary S. Price, *Enforcement Discretion and Executive Duty*, 67 VAND. L. REV. 671, 691 (2014). As part of the constitutional settlement after the Glorious Revolution, "the monarch was henceforth denied suspending and dispensing powers" in "[t]he very first two articles of the English Bill of Rights of 1689," which state: "the pretended power of suspending of laws, or the execution of laws, by regal authority, without consent of parliament, is illegal," and "the pretended power of dispensing with laws, or the execution of laws, by regal authority, as it hath been assumed and exercised of late, is illegal." *Id.* (citing authorities).

II. Cost-Sharing Subsidies.

Section 1402 of the Act requires insurance companies to reduce co-payments, deductibles and other costs to qualified individuals who purchase health plans in public insurance exchanges. The section then combines with Section 1412(c)(3) to authorize federal payments to insurance companies to offset the price of the statutorily-prescribed cost-sharing reductions to insureds. In its FY2014 budget submission the Executive Branch requested appropriations for these payments. When Congress did not authorize them, the Department of Health & Human Services responded that for purposes of "efficiency" it would fund the payments out of the "same account from which the premium tax credit portion of the advance payments are made."[6] But the tax credits are funded through a permanent appropriation that does not reference the Act's cost-sharing provisions. The administration's expenditure of nearly $3 billion in offset funds thus raises the question whether agency implementation of the Act's cost-sharing provisions violates Article I's prohibition on expending public funds without an appropriation made by law.[7]

On February 3 of this year, the Chairmen of the Committees on Ways and Means and Energy and Commerce sent letters to Treasury Secretary Lew and Health and Human Services Secretary Burwell asking for "a full explanation for, and all documents relating to" the administration's payment of cost-sharing subsidies.[8] The agencies' response concedes that $2.997 billion in such payments were made in 2014, but refers questions about the legal basis for

[6] Ltr. from S. Burwell to T. Cruz, M. Lee (May 21, 2014).

[7] A July 2013 letter from the Congressional Research Service observes that "unlike the refundable tax credits, these [cost-sharing] payments to the health plans do not appear to be funded through a permanent appropriation. Instead, it appears from the President's FY2014 budget that funds for these payments are intended to be made available through annual appropriations."

[8] Ltrs. from F. Upton, P. Ryan to S. Burwell, J. Lew (Feb. 3, 2015).

these payments to the administration's filings in a pending lawsuit.[9] Regardless how that suit is resolved, it is unlikely to moot the need for continuing legislative oversight and political branch engagement on the affected provisions.

The Supreme Court has held that the utilization of appropriated funds within a statutorily-prescribed category is a proper executive function,[10] and that agency authority to administer statutory provisions is greatest where the relevant provisions are ambiguous.[11] But this administrative and interpretive authority comes into play only where there is a valid legislative appropriation in the first place, and the only appropriation the administration has identified with respect to the Act's cost-sharing provisions is a provision that is linked to tax credits that exclude insurance subsidies.[12] Absent some ambiguity in these provisions or a plausible interpretation of the Act that includes insurance subsidies in existing appropriations, the administration's cost-sharing payments are vulnerable to challenge under constitutional separation of powers principles and the Administrative Procedures Act.[13] And if such challenges succeed, the political branches will have to confront how to fund the subsidies or administer the Act without them.

III. Premium Tax Credits.

In an effort to make health insurance affordable to people required to purchase it, Section 1401(a) of the Act provides tax credits for insurance purchased on "an Exchange established by

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[9] Ltr. from R. DeValk, J. J. Esquea to P. Ryan (Feb. 25, 2015) (citing No. 1:14-cv-01967, *House of Representatives v. Burwell* (D.D.C. 2015).)

[10] *Id.* at 726, 732, 733; *see also id.* at 760 (White, J., dissenting).

[11] *Chevron USA, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).

[12] The law requires that an "issuer" of a qualified health plan to an eligible insured individual "shall reduce the cost-sharing under the plan at the level and in the manner" specified. 42 U.S.C. § 18071(a)(2). The issuer then "shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A). But the appropriations provision for tax credits the Treasury Department

[13] 5 U.S.C. § 706(2).

the State under section 1311." 26 U.S.C. § 36B(c)(2)(A)(i). The Executive Branch recently issued regulations applying these credits to coverage purchased on federal exchanges created by the U.S. Department of Health and Human Services under Section 1321 of the Act.[14] These rules are being challenged in the Supreme Court as unconstitutional legislation via regulation. The petitioners in *King v. Burwell* assert that the administrative provision of credits for insurance purchased on exchanges established by federal agencies under Section 1321 impermissibly rewrites the Act's express provision of such credits only for insurance purchased on exchanges "established by [a] State under section 1311." The petitioners argue that this textual limitation is both unambiguous and logical because the tax credits were enacted to incent States to establish exchanges that the Tenth Amendment prohibits Congress from requiring them to adopt. That these inducements have not moved most States to create exchanges is a fact the administration cites in support of applying Section 1311 credits to purchases on federally-created exchanges. Indeed, the Executive Branch has defended that interpretation of Section 1311 as the only position consistent with federalism principles and the Act's affordable care mandate, because refusing to provide tax relief to individuals who must purchase insurance on federally-created exchanges could make insurance so costly that States would feel compelled to establish exchanges in order to avoid so-called "death spirals" in their insurance markets.

The Supreme Court engaged these and other separation of powers questions relevant to Section 1311's administration in March. Justice Ginsburg began by raising a threshold question about whether Petitioners had standing to challenge the contested regulations in federal court. Justices Kagan, Ginsburg, Breyer and Sotomayor then questioned whether Petitioners' reading of Section 1311 could be reconciled with the Act's affordable care mandate. Justice Kennedy

[14] Specifically, the IRS regulations define "Exchange" to include both federal- and state-established exchanges, 45 C.F.R. § 155.20, and extend eligibility for tax credits to taxpayers enrolled through an Exchange so defined, 26 C.F.R. § 1.36B-1; 26 C.F.R. § 1.36B-2.

expressed concern that if Petitioners "prevail in the plain words of the statue," a "serious constitutional problem" might arise because States would feel compelled to support exchanges in order to secure tax relief for their residents.[15] Justice Scalia then probed what the "consequence" of any such "unconstitutionality" would be, and prompted counsel for both parties to concede there is no case that says when a statute contains a "clear provision [that] is unconstitutional, [the Court] can rewrite it."[16] He next pressed the Solicitor General to admit that, at least "theoretically," Congress could address any "disastrous consequences" of Petitioners' position by "enact[ing] a statute that takes care of the problem."[17] And Justice Alito offered that if the Court were to invalidate the challenged regulations, it could allow time for a legislative response by "stay[ing] the [Court's] mandate until the end of this tax year."[18]

Last but not least, Justice Kennedy questioned the argument that the Court should defer to the Administration's interpretation of Section 1311 because the provision is ambiguous. He observed that Congress was unlikely to hide the "elephant" of "how billions of [dollars] of subsidies are to be disbursed" in the "mousehole" of an ambiguous provision that would "leave that call to an IRS reg," particularly when the "director of Internal Revenue" had never identified any such ambiguity or raised it with Congress.[19] And the Chief Justice noted that if the Administration's position on ambiguity were correct, "that would indicate that a subsequent administration could change th[e] interpretation" of the statute in new regulations.

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[15] No. 14-114, *King et al. v. Burwell*, Tr. at 16:20-23 (U.S. Sup. Ct., Mar. 4, 2015).

[16] *Id.* at 17:18-20.

[17] *Id.* 54:10-17; 54:19-23.

[18] *Id.* at 53:1-4.

[19] *Id.* 74:16; 75:6-9; 76:12-15.

The questions the Supreme Court explored in *King*, like the broader constitutional questions surrounding the administration of ACA's employer mandate, cost-sharing, and tax credit provisions, illustrate why the Constitution requires all three branches independently to assess and adhere to separation of powers principles in enacting, implementing and reviewing complex legislation. The Declaration of Independence recognized the hazards of concentrating power in a single person or body, and the Constitution answered this concern with a division of government authority that is often described as "the essential basis of a free system of government."[20] The scope and importance of the issues the ACA seeks to address can tempt government action beyond constitutional confines, particularly in the face of difficult or shifting economic and political circumstances. But it is precisely when government action is most consequential and policy divisions run deepest that constitutional principles and the rule of law must serve as a check on the exercise of government power. History suggests that laws and practices that push separation of powers boundaries cause problems that cut across policies and administrations. Accordingly, adherence to these boundaries should not be viewed as a partisan issue or merely a matter for the courts.

The pending lawsuits in *King* and *House v. Burwell* illustrate why. *First*, both cases are subject to settled constitutional limits on judicial authority that may prevent certain statutory infirmities or administrative transgressions from reaching federal courts. And even where judicial review is available, the pending ACA suits highlight why each branch has an independent obligation to adhere to separation of powers limits and scrutinize the implementation of complex legislation over time. *King* began with the passage of a law whose funding and structure is tied to State actions that Congress cannot mandate and the Act apparently did not incent to the degree its supporters expected. In passing a law dependent on

[20] M.J.C. VILE, CONSTITUTIONALISM AND THE SEPARATION OF POWERS 133 (2d ed. 1998).

future funding and provisions for state action that could not necessarily be enforced as written, Congress arguably invited the separation of powers questions that now surround various aspects of the Act's implementation. The statute's funding and structural limitations created implementation challenges for its tax credit and cost-sharing provisions that resulted in the regulations this Committee has questioned and the *King* and *House v. Burwell* suits seek to invalidate. And those suits in turn require the courts to confront constitutional limits on their authority to depart from unambiguous statutory provisions or defer to administrative actions out of fear that doing otherwise will have consequences Congress cannot be counted upon to address.

The resolution of these questions in *King* and *House v. Burwell* may guide future administration of the Act, but will not moot the need for the political branches to engage separation of powers questions in ACA's implementation going forward. No matter how the pending suits are decided, the Executive Branch will have to assess how it can continue administering the statute, and Congress will have to oversee these efforts and consider legislative action where circumstances appear to render the implementation of certain provisions unworkable within constitutional bounds. That is particularly true because the Act itself contains provisions that allow States to seek Executive Branch waivers of certain statutory requirements, including those at issue in *King*, in the coming years.[21] Constitutional limits on federal jurisdiction would leave the interplay between such provisions and the Supreme Court's interpretation of Section 1311 to the political branches. And the manner in which federal

[21] Other provisions that may be waived under section 1332 include (i) Part I of subtitle D to ACA Title I (requirements related to the establishment of qualified health plans), (ii) Part II of subtitle D to ACA Title I (requirements related to consumer choices and insurance competition through exchanges), (iii) section 1402 of the ACA (requirements related to reduced cost sharing for individuals enrolling in qualified health plans), (iv) section 4980H of the Internal Revenue Code (requirements related to shared responsibility for employers regarding health insurance), and (v) section 5000A of the Internal Revenue Code (requirements related to tax penalties for the failure to maintain essential health insurance). ACA § 1322; 77 Fed. Reg. 11701.

agencies implement the constraints the Act places on state waivers,[22] could raise constitutional and APA issues as or more challenging as those presented in *King*. As these issues unfold, this Subcommittee's continued exercise of its oversight authority will be critical to ensuring implementation of Section 1332 and other provisions consistent with the separation of powers and federalism limits the Constitution requires.

[21] Section 1332 waivers are not available until 2017. ACA § 1332(a)(1), and even then are available only if a State shows that its innovation plan will (i) provide benefits at least as comprehensive as those required in ACA exchanges, (ii) provide coverage and cost sharing protections against out-of-pocket spending to make coverage at least as affordable as those provided by the ACA, (iii) cover at least a comparable number of residents as would be covered under the ACA, and (iv) not increase the federal deficit. ACA § 1332(b)(1).

Chairman ROSKAM. Thank you.
Mr. Weiner.

STATEMENT OF ROBERT N. WEINER, PARTNER, ARNOLD & PORTER LLP

Mr. WEINER. Thank you, Mr. Chairman, Ranking Member Lewis, Members of the Committee. I want to make clear that I testify today only on my own behalf. I am not representing any clients.

Administrative agencies exercise power delegated by Congress and oversight to ensure that they are properly doing so. And legislative action, if Congress finds they are not, is integral to the system of checks and balances that underlies our constitutional structure. But I submit that the opponents of the ACA have disrupted that system of checks and balances through legal and extralegal efforts to thwart implementation of the law.

From 7 minutes after the law was signed, litigation has continued unabated to this very day. Other efforts to obstruct implementation and even to discourage individuals and organizations from helping families to get insurance have abounded. The Georgia insurance commissioner admitted that the government there was doing all it could to obstruct ObamaCare. And I submit that is not the rule of law.

Nevertheless, the Affordable Care Act is working. More than 14 million people have gained access to insurance. The uninsured rate has dropped from 20 percent to 13 percent of the population. Americans can no longer be denied insurance based on pre-existing conditions, and the healthcare price inflation is at its lowest rate in 50 years.

Now, Congress can't anticipate in this Act or in any major legislation the stumbling blocks to implementation, and that is why it has given administrative agencies the discretion that is necessary to deal with such obstacles, which brings us to the postponement of the employer mandate.

Now, the ACA opponents have portrayed this as inimical to the fundamental precepts of our democratic structure. In fact, it was within the bounds of administrative discretion, as exercised by prior Administrations. As of July 2013, it appeared that business wouldn't be ready to make the required reports about who was getting insurance and how much or that Treasury would be ready to process those reports.

Treasury, therefore, announced transition relief, allowing the IRS time to simplify and phase in the reporting requirements—not the mandate; the reporting requirement—and it talked about enforcement of the reporting requirement. Now, the problem was, without the reporting, it was impossible to enforce the mandate; and, therefore, it was necessary for Treasury to postpone that as well.

But let's be clear. The Department didn't rescind the employer mandate nor did it waive it indefinitely. Now, this is hardly an assault on the foundations of the republic. It is an exercise of administrative discretion to facilitate compliance, and there is ample precedent.

Ms. Papez may not think those precedents are on point, but Michael Leavitt, President Bush's HHS Secretary, described the delay

of the mandate as wise and consistent with the phase-in of the Medicare prescription drug benefit done in his Administration.

Now, another major focus of attack is the IRS regulation confirming that subsidies are available to enable consumers to get health insurance in States with Federal exchanges. The fundamental tenet of this attack is that there is one and only one permissible interpretation of this statute.

But, apparently, at least four Supreme Court justices, the Solicitor General, leading experts of statutory interpretation, the House and Senate Members and staffers involved in drafting the ACA, the principal association of health insurers, the Hospital Corporation of America, the American Heart Association, 22 States, plus the District of Columbia, and many others read it the way the IRS did.

And unless we are going to challenge either the candor or the literacy of those institutions and individuals, that is a permissible reading and it is a reading that is consistent with the purpose of the statute and that doesn't gut the statute.

In short, if the Committee is looking for executive overreach, I submit that it is looking in the wrong place. But, with all due respect, I would say, Mr. Chairman, that, on the broader issues, there are two ends of Pennsylvania Avenue and that the level of administrative activity is reflective of the dysfunction of this institution.

Congress can pass legislative hammers to deal with administrative overreach. It can deal with problems in the implementation of the statute. And it is the inability to do that that has led to administrative actions here.

Because I think that is ultimately unsustainable, I think that the current snapshot of the ebb and flow of power between the executive and the congressional branch is not a basis for long-term concern. Thank you.

[The prepared statement of Mr. Weiner follows:]

PREPARED STATEMENT OF ROBERT N. WEINER

Thank you, Chairman Roskam, Ranking Member Lewis, and the Members of the Subcommittee, for inviting me to testify today regarding the use of administrative actions in the implementation of the Affordable Care Act. My name is Robert Weiner. I am a partner at the law firm of Arnold & Porter LLP in Washington, D.C. From 2010 to 2012, I was an Associate Deputy Attorney General at the U.S. Department of Justice, where I oversaw the legal defense of the Affordable Care Act ("ACA"). Since leaving the Justice Department, I have written, lectured, and debated about the ACA and its implementation. I also taught a course at the Georgetown University Law Center on "The Litigation of Politics and the Politics of Litigation," based in part on my experience with the ACA. I appear today solely to present my personal views, not as an attorney or spokesman for any individual or organization.

Administrative agencies exercise power delegated by Congress. It is appropriate for this Committee and for the Congress as a whole to conduct oversight to ensure that agencies are properly using that delegated authority. If Congress finds that they are not, it has legislative remedies at its disposal. Proper oversight and legislative action flowing from it are integral to our democratic system of checks and balances.

Opponents of the Affordable Care Act, however, have disrupted and circumvented this system of checks and balances through lawsuits and efforts to stymie implementation of the law. The President signed the Affordable Care Act on March 23, 2010. The first lawsuit came seven minutes later. Even though the Supreme Court in that lawsuit upheld the constitutionality of the Act, litigation seeking—in the words of one advocate—to "drive a stake through the heart of Obamacare" has continued unabated for every minute, except those first seven, of the five years the Act has been in force. This trench warfare against the ACA includes a case rejected by the

Court of Appeals for the Fifth Circuit last month alleging that the ACA violated the Origination Clause of the Constitution. It includes another case, dismissed last week, attacking the "transitional policy" and "hardship exemption," which permit individuals temporarily to maintain health insurance coverage through plans not compliant with the general requirements of the Act. It includes a lawsuit by a Senator rejected by the Seventh Circuit last month, and one by this House, which will likely share the same fate in DC. And it includes the pending Supreme Court case, *King v. Burwell*, asking the Court to interpret the ACA in a manner that Congress plainly did not intend and that would take subsidies away from 9.3 million people who need the money to afford health insurance. Lawsuits, moreover, are only part of the assault, as opponents of the ACA at the state, local, and federal level have sought at every turn to impede its implementation, to discourage organizations from helping people get insurance, and, along the way, to block access to affordable health insurance.

And yet, despite it all, the ACA is working. Since the beginning of open enrollment in October 2013, 14.1 million adults have gained health insurance coverage, not including the 2.3 million young adults who have been able to stay on their parents' insurance policies until the age of 26.[1] The uninsured rate has dropped from 20.3 percent of the U.S. population to 13.2 percent.[2]

But those numbers do not tell the whole story.

In the *King* case, the Hospital Corporation of America (HCA), the nation's largest non-governmental health care provider, filed an *amicus* brief identifying other ways in which the

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[1] *See* U.S. Department of Health and Human Services, *HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT* (May 5, 2015) available at http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

[2] *Id.*

Affordable Care Act is working effectively. HCA reported, for example, that the Act is encouraging personal responsibility. While 90 percent of uninsured patients pay HCA nothing at all for their health care, patients who purchased insurance on the federal exchanges pay an average of $390 out-of-pocket for their care. This gives them a direct financial stake in maintaining their health, making better health care choices, and using less expensive types of care. HCA reported further that patients on federal exchanges are three times less likely than uninsured patients to seek health care in an emergency room. Reducing the use of emergency rooms for primary care was one of the ACA's objectives, and it both reduces costs and fosters better preventive care.[3]

No one could contend that implementation of the ACA has been seamless. Few, if any, major statutes anticipate all the stumbling blocks in implementation. That is one reason why Congress has afforded administrative agencies the discretion necessary to deal with delays, obstacles, and unexpected events, so that they can achieve what Congress intended in enacting new legislation. Despite such inevitable snags, and despite the relentless opposition, the Executive Branch has succeeded in implementing the ACA by judiciously exercising that discretion the same way prior Administrations have done in implementing complex statutes.

One of the administrative actions that opponents of the ACA have attacked is the IRS's one-year postponement of the January 1, 2014 deadline for large employers to provide their workers with health insurance or pay a tax.[4] Opponents of the ACA and the Administration have decried this transition relief as if it were some czarist decree. Whatever the political salience of

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[3] Brief of HCA Inc. as *Amicus Curiae* in Support of Responds and Affirmance, *King v. Burwell*, No. 14-114 (Jan. 2015), http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/BriefsV5/14-114_amicus_resp_hca.authcheckdam.pdf.

[4] White House Statement, "We're Listening to Businesses about the Health Care Law" (July 2, 2013), available at <http://www.whitehouse.gov/blog/2013/07/02/we-re-listening-businesses-about-health-care-law>.

this narrative, it has little connection with the legal reality. The postponement in fact was well within the historical bounds of administrative discretion as a transitional phase-in of a new requirement.

The employer mandate depends on complex reporting requirements that inform the government as to what insurance employers are offering and to whom. Without this information, the IRS cannot enforce the mandate effectively. In July 2013, the Treasury Department announced that it was providing "transition relief," to allow the IRS "to simplify the new reporting requirements consistent with the law," and to "provide time to adapt health coverage and reporting systems while employers are moving toward making health coverage affordable and accessible for their employees."[5] The Treasury Department found that it would be "impractical" without the reports to determine which employers owed a tax penalty for failing to provide insurance to employees—the kind of determination an administrative agency is uniquely well-situated to make. Based on that finding, the Treasury Department granted transitional relief as to that obligation as well. The Department, however, did not suggest that it could or would rescind the employer mandate, or waive it indefinitely. The Department spoke of "transitional" relief, limited in scope and time, while the IRS engaged in a "dialogue with stakeholders" to develop effective reporting requirements that did not impose undue burdens.[6]

The Treasury Department issued the proposed reporting rules on September 5, 2013. In doing so, it confirmed that the proposal reflected "an ongoing dialogue with representatives of

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[5] Mark J. Mazur, United States Department of the Treasury, "Continuing to Implement the ACA in a Careful, Thoughtful Manner" (July 2, 2013), <http://www.treasury.gov/connect/blog/pages/continuing-to-implement-the-aca-in-a-careful-thoughtful-manner-.aspx>.

[6] Letter from Mark J. Mazur, United States Department of the Treasury to the Honorable Fred Upton, Chairman, Committee on Energy and Commerce, Washington, D.C., 9 July 2013, <http://democrats.energycommerce.house.gov/sites/default/files/documents/Upton-Treasury-ACA-2013-7-9.pdf>.

employers, insurers, and individual taxpayers," which would continue through the notice and comment rulemaking process.[7] With further fine-tuning based on that dialogue, the Administration issued the final rules on February 10, 2014. In them, the Administration included additional "provisions to assist smaller businesses," and sought "to ensure a gradual phase-in and assist the employers to whom the policy does apply. . . ." Thus, the final rules apply the employer mandate starting in 2015 to larger firms with 100 or more full-time employees, and wait until 2016 to apply it to employers with between 50 and 100 full-time employees. And rather than demanding immediate, across-the-board compliance, the rule requires employers to provide insurance to 70 percent of their full-time employees in 2015 and 95 percent in 2016 and beyond.[8]

This is hardly the stuff of czarist tyranny. It is, rather, the prudent exercise of administrative discretion, based on a productive dialogue with the business community, to avoid disruption and achieve better long term compliance by phasing in new requirements instead of imposing them abruptly. It reflects the practical reality of implementing any significant legislative change affecting organizations across the country. Moreover, there is ample precedent for such a measured approach. In fact, shortly after the Treasury Department announced the postponement, Michael O. Leavitt, the former Utah Governor and President George W. Bush's HHS Secretary, described the decision to delay the employer mandate as "wise," and consistent with the Bush Administration's similar phase-in of the prescription drug benefit to Medicare adopted in 2003 and implemented in 2006. The Bush Administration, in

[7] United States Department of the Treasury Press Release, "Treasury Issues Proposed Rules for Information Reporting by Employers and Insurers Under the Affordable Care Act" (September 5, 2013), <http://www.treasury.gov/press-center/press-releases/Pages/jl2157.aspx>.

[8] U.S. Treasury Department, Fact Sheet accompanying "Final Regulations Implementing Employer Shared Responsibility Under the Affordable Care Act (ACA) for 2015." http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%20021014.pdf.

implementing Medicare Part D, delayed, modified, and transitioned-in various portions of the new law. For example, the Administration waived the penalty for late enrollment, delayed enforcement of a requirement that participating drug plans establish programs for managing the medication therapy for patients with multiple chronic health problems, and postponed elements of the method for calculating the beneficiaries' share of drug premiums, in order to keep premiums low in the first years of the program.[9]

In a letter to Chairman Upton of the House Energy and Commerce Committee in 2013, Assistant Treasury Secretary Mazur cited other "prior occasions across Administrations" where the IRS had used its statutory discretion to "postpone the application of new legislation." For example, he said:

> [T]he Small Business and Work Opportunity Act of 2007 made changes to the standards return preparers must follow to avoid penalties. The amendments were effective May 25, 2007. On June 11, 2007, the Treasury Department released Notice 2007-54 providing that the IRS would follow the standards in prior law in determining whether to assert penalties for returns due on or before December 31, 2007. Similarly, the Airport and Airway Extension Act, Part IV (signed August 5, 2011) reinstated the air transportation and aviation fuels excise taxes retroactively to July 23, 2011, when they had expired. On September 9, 2011, the Treasury Department released Notice 2011-69 providing that the excise taxes would not imposed on purchases of air transportation services made after July 22, 2011 and before August 8, 2011.[10]

Similarly, the EPA, under both Republican and Democratic Administrations, has often phased-in requirements past statutory deadlines, to avoid actions lacking scientific support or at odds with other mandates. In 2012, for example, the EPA delayed the Secondary National Ambient Air Quality Standards for Oxides of Nitrogen and Sulfur, because the EPA found the

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[9] Corlette, S., Hoadley J., "Are the wheels coming off the ACA wagon? History suggests not." The Hill Congress Blog, July 17, 2013, http://thehill.com/blogs/congress-blog/healthcare/311441-are-the-wheels-coming-off-the-aca-wagon-history-suggests-not.

[10] Mazur, *supra* note 5.

science too uncertain to allow formulation of the new standards. Nor was this delay unusual. Back in April 2005, EPA had completed only 404 of the 452 actions required by the Clean Air Act Amendments of 1990. And, of the 338 requirements with statutory deadlines before April 2005, EPA completed 256 late.[11]

Of course, at some point, delay becomes tantamount to abandonment or non-enforcement of a statute. That was effectively what the Supreme Court found when it ordered EPA in the Bush Administration to initiate formal rulemaking to determine whether greenhouse gases were subject to regulation under the Clean Air Act. *Massachusetts v. EPA*, 549 U.S. 497 (2007). Even after this decision, charges persisted that the Administration was pursuing a policy of "deregulation through non-enforcement."[12] But plainly, that is not what is happening with regard to the Affordable Care Act. The Obama Administration supports the ACA and has taken steps—temporary and successful steps—to enable the law to function effectively.

The federal Administrative Procedure Act ("APA") demarcates the boundaries of administrative discretion regarding timing in the implementation of statutory mandates. The APA authorizes federal courts to compel statutorily mandated actions that agencies have "unreasonably delayed."[13] But the circumstances constituting unreasonable delay are nothing like those presented here. Courts have found such unreasonable delay only after years of regulatory inertia, where the foot-dragging agency could neither provide a good explanation nor commit to an imminent deadline. Before overriding an administrative delay, moreover, courts

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[11] EPA has completed most of the actions required by the 1990 Amendments, but many were completed late. GAO-05-613: May 27, 2005, http://www.gao.gov/products/GAO-05-613.

[12] Daniel Deacon, *Deregulation Through Nonenforcement*, 85 N.Y.U.L.Rev. 795 (2010); Felicity Barringer, *White House Refused to Open E-mail on Pollutants*, N.Y. Times, June 25, Five Lessons from the Clean Air Act Implementation, Pace University Env. L. Rev. (September 1996), http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1365&context=pelr

[13] Administrative Procedure Act, 5 U.S.C. § 706.

must assess whether compelling agency action could adversely affect "higher or competing" administrative priorities, and whether other interests could be "prejudiced by the delay."[14] The Supreme Court has presumed that an administrative agency understands better than the courts do "the many variables involved in the proper ordering of its priorities."[15] The Court has thus required deference to Executive Branch decisions on timing unless an "agency has consciously and expressly adopted a general policy that is so extreme as to amount to an abdication of its statutory responsibilities."[16] Despite the fervent hopes of some, the Obama Administration has not abdicated its responsibility to implement the Affordable Care Act, and there is no risk that it will.

Another administrative action attacked as unlawful is a letter from HHS to state insurance commissioners announcing a "transitional policy" permitting health insurers to "choose to continue coverage" for an additional year under policies commencing between January 1 and October 1, 2014, which would otherwise be terminated or cancelled" for non-compliance with insurance reforms under the ACA.[17] The letter stated that "State agencies responsible for enforcing the specified market reforms are encouraged to adopt the same transitional policy with respect to this coverage." Here, too, the Administration did not change the law, or waive the statutory requirement. Rather, in the exercise of prosecutorial discretion, HHS announced a "transitional" *enforcement* policy for the federal government, which states were free to follow or not. Many did not. This policy, too, is the type of reasonable interim adjustment that courts have found to be within the zone of administrative discretion.

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[14] *Telecommunications Research and Action Center, et al. v. FCC*, 750 F.2d 70, 80 (1984).

[15] *Heckler v. Chaney*, 470 U.S. 821, 831-32 (1985).

[16] 470 U.S. at 833 n.4.

[17] http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

A third ACA regulation subject to attack is the one at issue in *King v. Burwell*, in which the IRS confirmed that subsidies were available to enable consumers to afford health insurance in states with federal exchanges. Some have described this interpretation of the statute as an assault on liberty. Let's come back to reality. To the opponents of the ACA, the language of the statute clearly commands one and only one interpretation. But, apparently, at least four Supreme Court Justices, the Solicitor General, leading experts in statutory interpretation, Senate and House leaders involved in drafting the ACA, key staffers leading the drafting process, the principal association of health insurers, the Hospital Corporation of America, the American Hospital Association, the American Cancer Society, the American Heart Association, 22 states and the District of Columbia, and countless others read it the same way the IRS does. It is a fair inference that their reading is, at the very least, a permissible interpretation of the statute. It is also the reading that advances the statutory purpose of making affordable insurance available to all Americans, avoids gutting numerous provisions of the law, and prevents the collapse of the statutory structure. It is the reading consistent with the contemporaneous legislative record, not one discovered only months after enactment of the law in an unabashed search for statutory glitches. And it is the interpretation that fulfills the Executive's duty to "take Care that the Laws be faithfully executed."

Congress should indeed hold the Executive Branch to that duty. But wrapping political or policy disagreements with the ACA or its practical implementation in baseless constitutional rhetoric, and predicting the death of freedom because of transitional relief from regulatory deadlines, serves no legitimate end. If the Committee is prospecting for Executive overreach or constitutional dereliction, the ACA is a dry hole.

Chairman ROSKAM. Well, thank you all. I really appreciate the discipline of your testimony. All four of you directly spoke to this legal question. And so I am going to encourage my colleagues to focus in on that same line of inquiry.

I am going to go to Mr. Kelly first.

Mr. Weiner, I just want to give you a heads-up on a question that I am going to give to you, but I will ask the question at the end. You can think about your response.

If Congress has been dysfunctional, how is it possible, based on Ms. Turner's observation, that 17 statutory changes have been signed into law by President Obama? So if you can marinate in that a little bit, we will come back.

And, with that, I will yield to Mr. Kelly.

Mr. KELLY. Thank you, Chairman.

I thank the panel for being here.

It is interesting we come to these hearings. This really has nothing to do with the healthcare law, but it does have to do with the health care of our Constitution. And I think this is the thing that probably bothers us more than anything else.

As I was leaving the office today, I asked our guys—I said, "Listen, please do me a favor. Look up our oath of office." And I am just going to go through this rather quickly. "I do solemnly swear or affirm that I will faithfully execute the office of the President of the United States and will, to the best of my ability, preserve, protect, and defend the Constitution of the United States."

I said, "Okay. Well, give me the definition of an oath." An oath is a solemn, usually formal, calling upon God or a God to witness to the truth of what one says or to witness that one sincerely intends to do what one says. It is a solemn attestation of the truth and viability of one's words.

Now, further, Webster's defines the law as a rule of conduct or action prescribed or formally recognized as binding or enforced by a controlling authority.

Now, having listened to all these different testimonies—and I read them last night—I really found it interesting. We have really gotten beyond the debate right now, and we have tried to go off to the side. And there is an old saying out there. It goes something like this, "If you can't convince them, confuse them."

And I have looked at what has happened, and I have to tell you, from what I do every day—I am an automobile dealer, and I have to follow laws as they are written. I don't have the ability to say, "You know what? I don't particularly care for this part of the law; so, I am just not going to follow that."

Here is another law that, you know what, I don't know what they were thinking about. Obviously, they didn't look far enough. They certainly didn't look at the private sector. But, then again, I have to run a profitable business to stay in business. They don't. And it comes down to where we are today with this discussion.

It is so difficult for those of us in the private sector to look at this and to think that this President or any future President can decide at his whim what parts of the law he is going to enforce or not enforce.

So the question then becomes: How do you prepare a business model when the rules change every day? It could be something

happens that it looks like, "Well, you know what? We didn't think about that part; so, we will just set that part aside" or, "There could be something else that has an influence on what we are going to do; so, we will set that part aside."

So, Ms. Turner, Mr. Adler, Ms. Papez, you are all very good at what you said. And I really find this to be very difficult. If this is the law—and it is the law and none of us are saying it is not a law and we have made changes to this law—my question is: Why does this President start to establish a precedent that is so dangerous for every President to follow? Because law is based on precedent.

And if we can go back in the future, if we can go back and say, "Yeah. But let me tell you how it happened back when we had the Affordable Care Act, and this is what we decided to do," how in the world would anybody living in this country look at any law and really look at it as a law? Because this one isn't a law if it is not going to be enforced. And if it is not enforced, it truly is just words on paper. It means absolutely nothing.

And the oaths of office that we have all taken are just words. They don't mean anything. Because if it doesn't come from your heart, if it doesn't come from who we basically are as Americans, and if we make this a political statement and not a statement to what you attest to, everything this country stands for, then we are missing the point. It is not about health care. It is about the health care of our Constitution.

So if I am off base, please inform me, because I am so confused in the private sector as to what actually is the law. And you know what? A deadline doesn't have any influence. It can come and pass and it could be changed.

So how would you advise people in the private sector to look at not only this law, but as time goes forward, how should we look at any law to prepare to somehow accommodate it or work within its confines? I just don't get it.

Ms. TURNER. I think, Congressman, that is the reason this hearing is so important and it is the reason the challenges before the Supreme Court are so important. The President may think that he can change the law at his will, but businesses don't.

Tens of billions of dollars have been spent by companies inside and outside the health sector to comply with this law. Individuals have to comply because there are penalties that will be enforced if they don't. So it is not optional for the American people to not comply.

And for the Administration to set a precedent I think does really get to a much larger question than this law. It really is fundamentally the rule of law. And the Supreme Court challenges I think get to that fundamental question.

Mr. KELLY. Let me just ask you one question, because maybe there is some confusion in the office of the President.

But what did the President do before he was elected President? My understanding is he came from the academic world. Right?

Ms. TURNER. He was a constitutional law instructor at the University of Chicago.

Mr. KELLY. Okay. So there really wouldn't be much cloudiness in his idea of what the Constitution is or what it contained.

I thank you all for being here.

And I yield back. Thank you.

Chairman ROSKAM. Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

This is very interesting. I want to welcome all of the witnesses and thank them for coming here. I am still trying to figure out why you are here and why we are having this hearing.

This is a very complex piece of legislation. I understand that some changes have been made legislatively which have been signed into law, which I guess is a good thing.

I also understand that the President has exercised executive privileges in other parts of the law that is very controversial and that these issues are before the United States Supreme Court.

So if, indeed, anything that the executive branch does violates the intrusions of legislation, I assume all of you agree that this is a proper subject not for the legislative body, but for the courts.

Are there any provisions that you believe that—any testimony that you have of any issues that are not now before the United States Supreme Court? And, if there are, what would you believe is the constitutional way that we should go?

This is not the Judiciary Committee. I have worked hard on this bill, and other Members have as well. It has been signed into law, approved by the Supreme Court. It has been debated. It has been voted on half a hundred times.

And so where does this go? Most of the testimony that is critical of the President, it is my understanding, as a lawyer, that that controversy belongs in the United States Supreme Court. It is a contest between the actions of the executive branch and those who differ with him.

So, Ms. Turner, Mr. Adler, what solution are you expecting your eloquent testimony to have on the constitutional issue in this legislative Subcommittee of Ways and Means?

Mr. Adler.

Mr. ADLER. Well, I mean, first of all, I think my testimony and I think some of the other testimony identify multiple instances where the Administration has taken actions that are not yet subject to litigation and may or may not be subject to litigation. Not everything the Federal Government does presents a justiciable controversy. There are limits on——

Mr. RANGEL. What has the President done that this Congress can do anything about? Isn't it a question of the interpretation of his action?

Mr. ADLER. Not at all. This Congress, as an institution, has a long history of conducting oversight to ensure that Federal agencies are complying with the letter of the laws that Congress enacts. Certainly when——

Mr. RANGEL. Mr. Adler, this is not just for this President. This is for Presidents that have been and those that follow.

Mr. ADLER. I agree.

Mr. RANGEL. Okay. Is not the issue whether or not the President of the United States exceeded his executive authority? Isn't that what this testimony is all about?

Mr. ADLER. Whether or not the——

Mr. RANGEL. Whether or not the President of the United States exceeded his constitutional authority. Isn't that the issue?

Mr. ADLER. That is certainly one of the issues.

Mr. RANGEL. And isn't it controversial?

Mr. ADLER. It is controversial.

Mr. RANGEL. And isn't it subject to debate by people who have honest opinions about what he has done, not only him, but Presidents before him? Isn't that correct?

Mr. ADLER. I agree. And that is why it is appropriate for a hearing, so that the points of view——

Mr. RANGEL. Appropriate for a hearing? Isn't it appropriate for the Supreme Court to decide the issue of whether or not the President acted in a constitutional way?

If we decide that he did not act, in our legislative opinion, accordingly, what do you want us to do, Mr. Adler, except to file suit in the Supreme Court?

Mr. ADLER. Well, when I first came to Washington, I remember then-Commerce Committee Chairman John Dingell, who would regularly hold hearings like this, looking at the actions of executive agencies and whether or not they complied with statutes. This has been going on for decades.

Mr. RANGEL. With all due respect, you are here. I am here. Will you please deal with the issue before this Committee.

Assuming you are correct in believing that the President exceeded his constitutional responsibility to the people of the United States and assuming that this Congress has voted 55 times to indicate their disapproval of the President's conduct, now, if you want to say that this is an extension of trying to get rid of the Act, which the Chairman says it is not, then we can ask: Do all of you believe the people in the United States should have access to affordable health care? Ms. Turner, Mr. Adler, Ms. Papez, Mr. Weiner, is that a goal that we should have?

Mr. ADLER. Sure.

Mr. RANGEL. Because, if you agree to it, let's get to how the President and the legislature decide it should happen. They have decided. The courts have decided.

And, Mr. Adler, I understand that you have had some input in the issue now before the court. Now, there has been a lot of publicity because of the personalities of the Members of this Committee, especially the Subcommittee Chairman, and people want to know what has come out of this hearing besides listening to eloquent testimony.

I submit, Mr. Chairman, that this argument should be across the street in the United States Supreme Court. We have things to do in this Congress. We have trade bills. We have an economy to build up. And if we want to beat up on the President, we have done a pretty good job here. Now let the Supreme Court take a look at it.

Does anybody object to what I am saying? Am I making any sense at all? Unless you want to talk about the eloquence of the arguments in the Supreme Court or go back to the Constitution, as our distinguished Chairman had—because it is very interesting when you bring up these people.

They were not thinking about people who look like me. They were not thinking about women. They were not thinking about anyone that didn't hold any land. But in this great country, the Constitution has been flexible enough to include all of the things that these old white men forgot to include, which is good.

Having said that, don't you think this is a judiciary issue?

Mr. ADLER. Oversight of the executive branch's enforcement and administration of the law has been a proper subject of legislative oversight for decades. I have been doing this for over 20 years.

Mr. RANGEL. After 55 votes——

Chairman ROSKAM. The gentleman's time has expired.

Mr. RANGEL. Would you consider 55 votes to be proper oversight?

Chairman ROSKAM. Go ahead, Mr. Adler. Why don't you bring us home.

Mr. ADLER. I was going to say, you know, I have been doing regulatory policy for over 20 years. I have attended hearings and testified at hearings like this, looking at the actions of executive agencies for about 20 years and looking at the actions of Presidents of both parties.

It has always been Congress' place to engage in such oversight. It is something that should be done without regard for the party of the President. And it is particularly important because not every action an agency takes that may violate the law can be subject to resolution and litigation.

And many of the examples that have been pointed to in our testimony——

Mr. RANGEL. Well, there——

Chairman ROSKAM. Look, we have been generous with the time.

Mr. ADLER [continuing]. Are not currently the subject of the litigation and may not even be within article III jurisdiction of the Federal courts.

Chairman ROSKAM. So we are going to turn to Mr. Holding.

But before we do, I will make an attempt to answer Mr. Rangel's question, and the answer is twofold.

Number one, silence is assent. So if Congress doesn't assert itself in the form of a hearing, in a subsequent Congress, we would see someone on the House floor to say, "There is no argument here. Congress is complicit in this."

So silence is assent. We all know that. And what we are choosing to do is say, "Look, we are not going to be silent if we are making an argument that we think the Constitution has been abused."

Second, we have a specific admonition from the House, and that is under House rule 10. We are to determine whether laws and programs are being implemented and carried out in accordance with the intent of Congress. So we are well within our purview. It makes perfect sense for us to be discussing that.

And to give us some more insight, we will now yield to the gentleman from North Carolina, Mr. Holding.

Mr. HOLDING. Thank you, Mr. Chairman.

So when the President was trying to sell this healthcare plan, he promised over and over again, "If you like your healthcare plan, you can keep it. No one will take it away, no matter what."

Now, subsequently, we have learned this was completely false, and people who lost the coverage they liked were understandably upset and certainly made it a very large issue in the subsequent election. So the Administration's response to this was to unilaterally change the law.

So, Professor Adler, you know, we can agree that the policy result that individuals shouldn't be forced to give up the coverage they like and that the burden on employers should be limited, but the law doesn't give the Administration that kind of flexibility without Congress. Correct?

Mr. ADLER. Well, certainly the law does not give the Administration the authority to do what it did. It is possible that there are other ways the Administration might have been able to extend the grandfathering of plans.

It could have, for example, tried to issue a regulation, redefining what constitutes a grandfathered plan by going through the notice and comment rulemaking process.

The Administration chose not to do that. I don't know if that is because they determined that it wouldn't be quick enough or might itself be subject to litigation. But certainly the way the Administration tried to address this issue was not consistent with traditional legal principles.

Mr. HOLDING. Now, Ms. Turner, the Administration's job is to implement the law Congress passed, not to compensate for its shortcomings.

So isn't it our job, as Members of Congress, to fix the law if it doesn't work?

Ms. TURNER. Yes, sir. And I think that you did try to do that with the provision, the legislation, that was introduced and passed on a bipartisan basis in the House that would have allowed the legal authority to the Administration to allow those plans to continue even though they were not compliant with other provisions of ACA.

Mr. HOLDING. So when the President says that, you know, he had to act unilaterally because the Congress was dysfunctional and incapable of acting, that is patently false?

Ms. TURNER. That is right. You passed that legislation on a bipartisan basis. It died in the Senate. And the President threatened to veto it.

Mr. HOLDING. Now, you mentioned a little bit earlier the cost of compliance, healthcare companies, individuals, and so forth. And I thought Mr. Kelly brought up a very good point that, you know, if you are a business trying to put together a business plan and the rules of the game keep changing, then you are going to incur costs.

So, you know, are you aware of costs incurred by insurance providers when the President unilaterally said, "All right. I am going to go back and I am going to say that, 'You can keep these plans?'" Do you think that took the insurance companies by surprise?

Ms. TURNER. Absolutely. And it has caused enormous disruption, and it has actually caused premium increases for individuals that they were forced to pay because the healthy people they expected to come into the exchanges did not. They kept their old plans.

And, as a result, you found more older people with higher health costs in the exchanges, which are leading to higher costs. And I believe we are going to see even more of those in the coming year.

Mr. HOLDING. So when an insurance provider incurs these higher costs, you know, they can pass them on to other customers. But they can pass some of those costs back to the government as well, can't they?

Ms. TURNER. Absolutely. Through the subsidies. So taxpayers are paying as well. We are paying in a number of ways. Taxpayers are paying in the form of higher subsidies as well as individuals paying in the form of higher premium costs and out-of-payment costs and their networks and deductibles and other costs of insurance.

Mr. HOLDING. So, I mean, just to close the loop here, when the President decides to act unilaterally, you know, making a major change in this law, I mean, there are costs to the taxpayers in doing that. Correct?

Ms. TURNER. There are costs to taxpayers. There are costs throughout the entire system. And it really makes it extraordinarily difficult for companies to be able to invest in making changes that can help to make the law work when the law keeps changing, when the regulations keep changing.

Mr. HOLDING. Thank you, Ms. Turner.

Mr. Chairman, I yield back.

Chairman ROSKAM. Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman.

Mr. Weiner, in your written testimony, you described the Affordable Care Act as having lived through—and I will quote—a never-ending "trench warfare" of a tax from just about the moment of its enactment. That really creates a strong image about what it is like behind the scenes for those who work to put this law into effect.

There was and, frankly, still is a constant stream of criticism coming from the other side of the aisle, which is why I think it is important to clarify something for the record, if you can answer for me.

Exactly how long was the ACA in effect before the first lawsuit was filed against it?

Mr. WEINER. Seven minutes.

Mr. CROWLEY. I am sorry. Could you repeat that again.

Mr. WEINER. Seven minutes.

Mr. CROWLEY. Seven minutes after the law was enacted a lawsuit was filed against the law?

Mr. WEINER. Yes, sir.

Mr. CROWLEY. Opponents of the law waited a mere 7 minutes before filing against it. That is just remarkable. That is about the politics. But there is another number, and that number is 19. That number is 19. That is how many hearings this Committee has had on the Affordable Care Act since its enactment.

Let me put that number into context. If for every one of those hearings 1 million people got access to health insurance, it still would fall short of the 22 million Americans who got health coverage through the ACA.

Sadly, these hearings don't have that kind of positive effect. It is not as a result of these hearings that 22 million people have healthcare coverage today.

On the other hand, the Democrats on this Committee have asked the majority time and again to hold a hearing on a critical issue facing our country: Highway and infrastructure funding.

And the result, not one. Not a single hearing. Not a markup this year on the funding our States and cities desperately need to maintain and improve roads, bridges, and transit systems.

There always seems to be time for hearings to try to create falsehoods once again about the ACA and how it is somehow hurting job growth, even though 12 million American jobs have been added to the economy since the enactment of the ACA. But we have had not a single hearing this year on one of the biggest ways to create jobs in our country, providing a long-term infrastructure package.

Instead, yesterday, just yesterday, the House was forced to kick the can down the road once again for just another 2 months, leaving our States and local transportation agencies in limbo, without any foresight, without any, really, ability to plan for the future, without any vision.

And, sadly, I am not surprised. I love this Committee. I love this House and this institution. But it seems to me, under my Republican colleagues' control, we do a lot more looking backward instead of looking forward.

There seems to be a sentiment that it is better to score political points, get some press, and run campaign ads than it is to work together constructively to get things accomplished.

For 5 years, opponents of the law have refused any opportunity to work constructively to make it better or to offer a substitute for what they have tried to repeal 56 times. When Federal agencies use the implementing authority they have that they have used for hundreds of laws over the years, including the Part D program that President Bush signed into law, these same critics raise up a cry.

To all those critics of the law, I would say, maybe if you would stop trying to sue and repeal the law out of existence, you would be able to take a moment to work to improve the Act itself. All of us are ready.

We are here with bills and ideas—bipartisan bills—to make the law work even better for all. Every time we go through one of these hearings, I keep wishing it is the last one and that we can now work on real policy ideas. I do hope this is the last, but I doubt that it will be.

I really seriously question whether my colleagues on the other side of the aisle care about how this law is implemented, when, really, their only legislative attempts have been to repeal it 56 times.

That is all they have done.

So, with that, Mr. Chairman, I will yield back the balance of my time.

Chairman ROSKAM. Thank you, Mr. Crowley.

The good news is—and, Mr. Weiner, this is a heads-up. We are going to be coming back to you to answer Ms. Turner's point. Mr. Crowley didn't reference that.

So this narrative that Congress has an inability to deal with anything short of repeal, the argument that is going to come back to you, Mr. Weiner, is: There have been 17 times that Congress has taken this up. Therefore, it is a false claim to say that Congress has no capacity to do that.

So we are going to be in anticipation of your response, but right now we are going to go to Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

The President's health law made significant cuts to the Medicare Advantage program. These cuts are scheduled to go into effect in 2012. However, rather than allow these unpopular cuts to go into effect during an election year, whether it is 2012 or 2014, the Administration created a nationwide pilot program that basically undid the cuts.

Ms. Turner, can you describe the purpose of a pilot program?

Ms. TURNER. Pilot programs are designed primarily to test out an idea before we invest sometimes billions of dollars in Federal funds to make sure that that pilot program can work.

Mr. SMITH. So usually they test it in, like, a local community or maybe a local city or a State?

Ms. TURNER. Correct.

Mr. SMITH. Not the entire Nation for a pilot program?

Ms. TURNER. That is unusual.

Mr. SMITH. So that is virtually what was done in this case.

Do you know of any other situation that there has been a pilot program in any agency within the Federal Government that has been a pilot program for the entire Nation?

Ms. TURNER. I think that it would really stretch the definition of the term, Congressman.

Mr. SMITH. It doesn't sound like a pilot program to me, by any means.

Do you think this pilot was just a pretense to delay cuts to Medicare?

Ms. TURNER. There is certainly evidence that they have used this fund when they began to realize the consequences that these cuts would have to Medicare Advantage plans that now about a third of seniors have voluntarily enrolled in. And they, perhaps because of pending elections, decided that they needed to replace those funds even though those funds were a big pay-for for the new subsidies in the health law.

Mr. SMITH. It is a big deal. There are over 16 million seniors that are enrolled in Medicare Advantage—316,000 Missourians and 40,000 people in my district. You know, in fact, 39,354 people in my district. So that is a lot of people that could have faced some kind of significant cuts prior to an election in 2012 or an election in 2014, whenever the Affordable Care Act clearly said that these cuts needed to take place. It sounds a little fishy to me.

But Congress asked the Government Accountability Office to look at this program. GAO concluded that the design of the program probably would not produce meaningful results. GAO also raised questions about whether HHS had the legal authority to run the pilot in the first place, which causes great—whether it is a pilot or whatever you want to call it. At a cost of $8 billion, GAO noted,

"This is the most expensive pilot in history," which is very alarming and disturbing.

Pilots are intended to demonstrate whether certain approaches work, not to allow agencies to circumvent the statute; is that correct?

Ms. TURNER. That is correct, sir.

Mr. SMITH. Hardworking taxpayers in our district and across Missouri deserve a government that is accountable to them and that follows the law consistently. When this Administration failed to meet the legal requirements for a demonstration program and blatantly disregarded the law, America's seniors lost a lot. We can do better because our seniors deserve better.

With that, Mr. Chairman, I yield back the rest of my time.

Chairman ROSKAM. Thank you.

Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. Chairman, before I ask a question, I want to yield to Mr. Crowley for 2 seconds.

Mr. CROWLEY. Thank you, Mr. Chairman.

I just want to welcome to today's proceedings Liz Markee-Behrends. She is participating in the Foster Youth Shadow Day, and I am her victim. She is following me for the day. So I just want to welcome her to the Committee.

So thank you, Mr. Chairman.

Chairman ROSKAM. Welcome. Glad you are here.

Mr. Lewis.

Mr. LEWIS. Mr. Weiner, does the ACA allow people to receive tax credit for insurance purchased on the Federal exchange?

Mr. WEINER. Yes, it does.

Mr. LEWIS. You heard Members; you heard the other witness. Do you want to take some time to say anything about what you have heard?

Mr. WEINER. Yes. And let me say, Congressman Lewis, that it is an honor to be here and you are one of my personal heroes.

I think, when we talk about the actions of the Administration raising the costs of insurance, it flies in the face of the evidence that the costs of insurance have been going down. And so I think that is one of the things we need to focus on.

But focusing on the language of the statute that is at issue in King, when you read a statute, you don't read the provision by itself. And to listen to the attacks in the Court and elsewhere with regard to the tax credits, you would think that the statute said, "You shall not get a tax credit if you are in a State that has a Federal exchange." It doesn't say that. It never says that.

And the portion of the statute that talks about how you calculate the amount, after it says that everybody gets the credit and then it talks about calculating the amount, it calculates the amount by reference to insurance bought on an exchange established by the State.

And the argument is made that "established by the State" means established by the State. But the fact is that Congress defines its terms—this body can define "cat" to mean "dog" if it wants. But it defines "exchange," and the way it defines "exchange," the only way to read the statute that makes any sense is to say that the

Federal Government steps into the shoes of the State when the State doesn't establish its own exchange.

Mr. LEWIS. Well, thank you.

Mr. Weiner, some of my Republican colleagues seem concerned about the implementation of the law. They focus on Treasury's legal authority to delay the employer reporting requirement. Is there a Supreme Court precedent to support the agency's discretionary enforcement requirement?

Mr. WEINER. Yes. There is a major Supreme Court precedent. The leading one is a case called *Heckler* v. *Chaney*, and that relates to the enforcement discretion.

Courts are sensitive to the administrative priorities. And, you know, Congress sets deadlines at times, and sometimes they can't be met. Sometimes Congress gives the agency more than one priority, and the agency has to make choices with the budget that it has and the personnel that it has.

The Court has said that it will defer to the agency's determination on timing and that only when the action of the agency is so extreme that it amounts to an abdication of its responsibility to enforce the statute will the Court intervene. And that is the standard, and it is a standard against which this body has legislated. It is a longstanding standard. And so Congress, when it passes a law, knows that the Supreme Court has carved out that discretion for agencies in enforcing the statute.

Mr. LEWIS. Let me just ask, is it correct or true that numerous Administrations have delayed implementation of certain legislative provisions?

Mr. WEINER. Yes.

Mr. LEWIS. Do any come to mind?

Mr. WEINER. Well, Medicare Part D comes to mind, and the former HHS Secretary Leavitt said that the delay of the employer mandate was directly analogous. But there are other—there are many tax provisions, there are EPA provisions that have been delayed based on balance of priorities or on the state of the science or on any number of other grounds.

Mr. LEWIS. Are you still a partner at Arnold & Porter?

Mr. WEINER. Yes, I am.

Mr. LEWIS. I know the firm, and I want to thank you for all your great work. And I want to thank your firm for being back there during another period, during the height of the movement, and for all you have done for civil rights and civil liberties. Thank you for being here.

Mr. WEINER. Thank you.

Chairman ROSKAM. Before going to Ms. Noem, let me just ask Ms. Papez, the—Mr. Weiner referenced the case, *Heckler* v. *Chaney*. You mention that in your written testimony and also in your oral testimony. You have cited it today as precedent for, you know, the Administration to move forward.

Is that your view? Is there a different interpretation, or what do you think?

Ms. PAPEZ. I think the opinion actually speaks for itself. I don't think it stands for the proposition for which the agencies have cited it. The opinion says pointblank that what it is about is the execu-

tive branch's power to make discretionary judgments concerning the allocation of enforcement resources.

And some of the examples that have been given—we have articles that abound on this—is, you know, for example, if the Justice Department wants to ticket fewer jaywalkers so they can put more, you know, drug cases in jail, that is a fair exercise of enforcement discretion.

Some of the examples in the ACA implementation go well beyond that. I think that the best one is probably the Treasury Department's decision that the employer mandate—only 95 percent of employers have to participate from 2016 forward under the statute in the healthcare coverage. I mean, that really effects a permanent rewrite of the statute under the guise of transition relief. That is not executive enforcement discretion. That is a suspension or a rewrite of the statute as written.

And that is the point about coming back to the Congress. I mean, if there is a problem with implementing that provision as written, the solution is to come back to the legislature, not to have the executive branch revisit it wholesale.

Chairman ROSKAM. Thank you.

Ms. Noem.

Ms. NOEM. Well, Ms. Papez, I am going to stay with you because I want you to speak a little bit to that. And I also want you to talk about not only the cost to some of your clients that you have seen but also costs that you have seen them endure because of changes to the ACA over time that the Administration has made.

Ms. PAPEZ. This is an important point Representative Kelly made, as well, obviously, that predictability and knowing the rules of the road are not only constitutional requirements, they are also critical to enabling the government to administer a law in a way that is functionable for the private sector. And, you know, this is a fundamental requirement that we see in the Fifth Amendment, in the Due Process Clause, where everyone is entitled to fair notice of how a law is going to be administered.

And so I probably should have cited it in my written testimony; Richard Epstein at the University of Chicago issued an article about a year ago called "*Government by Waiver*" that kind of walks through more articulately I think than I will now the hazards of executive branch or agency discretion to grant waivers without fair notice or procedures so the private sector can understand how do they get relief from an Administration or an agency, what are the criteria for getting it, how should they structure their business activities to comply with the law, what kind of costs do they have to account for.

And this affects real people. It affects jobs, it affects benefits, it affects how someone makes payroll every month. And so these kind of deviations that we talk about, to the Chairman's point, are not theoretical.

Ms. NOEM. Yeah.

Ms. PAPEZ. You know, these limits on government acts are there for a reason, and they have very real-world consequences in the administration of a statute like this.

Ms. NOEM. It burdens on everyday people. And this Administration has done it not just in health care; they have done it in education and many other areas, as well.

Ms. PAPEZ. Well, and I think that is the point, right, that this is not confined to health care, but some of the ACA administration issues illustrate how dangerous it is when, you know, for policy or other reasons—and I don't purport to comment on those. The overarching point is, you know, an ends-justifies-the-means approach on any of these issues can create very dangerous precedents that have a ripple effect throughout the government, and they can come home to roost in other programs.

I also have to say, I thought it was interesting that Representative Rangel mentioned going across the street to the Supreme Court. The Supreme Court in the arguments in the King case last month emphasized that, because the Constitution limits the Court's authority to decide some of these issues, it can do its job to a point in examining whether a particular provision is implemented correctly.

And then to Mr. Weiner's point, it was the President's representative in the Supreme Court who said, well, if you interpret "State" to mean "State"—because this was not a case where this body defined "cat" means "dog" or actually defined, you know, "State" to mean "Federal Government." You know, the President's representative said, if you go with the literal interpretation of the statute, the statute will be broken, and all these subsidies can't flow to people, and we won't have affordable care, to which then some members of the Court said, well, then, the answer is bring it back to the Congress, which I understood to be the purpose of this hearing.

Ms. NOEM. Yes, and I want to touch on that before I run out of time. Because one of the things that alarms me the most is what the Administration does as ways to fund portions of this bill when Congress has not appropriated funds that were laid out strictly in the statute.

So can you briefly describe—because I want to follow it up with another question—the cost-sharing reduction program and the funding issues that we have had?

Ms. PAPEZ. All right. So the statute provides that the Federal Government can make payments to insurance companies to make them whole——

Ms. NOEM. To make up the cost difference.

Ms. PAPEZ. Right, to make them whole for money the insurance companies have to give to insurance on premium refunds and the like. And the question is, where does the Federal Government get this money?

The statute does not actually provide a permanent appropriation for those subsidies. And the Administration, actually, in the fiscal 2014 budget, asked this body to appropriate annual money for that. Congress did not do so.

The executive branch then said, as a matter of administrative efficiency, they were going to take the funds from a permanent appropriation under the statute for tax credits, but do not include these subsidies.

Ms. NOEM. Did they have the authority to do that——

Ms. PAPEZ. Well, that is exactly the question.

Ms. NOEM [continuing]. In your understanding?

Ms. PAPEZ. Right. The statute does not appear to give them the authority. And the Constitution says, if you don't—you don't have the authority as executive; Congress has the only power to appropriate money for public programs.

Ms. NOEM. And that is the authority that the Administration has, is to act under the discretion of what Congress directs them to do, correct?

I mean, I am elected by the people of South Dakota to come here to represent them, to pass laws, to decide what is taxed, what should not be taxed, how those funds should be spent.

When an Administration takes action like this and randomly pulls out of other funds to fund their priorities when Congress has not specifically given them the funds to do so, is that a dangerous precedent for us to be setting in this country?

Ms. PAPEZ. Well, certainly, because it goes to the fundamental issue of where do appropriations have to originate with the Congress. And then it goes to the fundamental point that the executive has discretion to administer funds within an appropriated box. It does not have the authority to go outside that box and pull funds in to administer appropriations.

Ms. NOEM. And it undermines our authority as Members of Congress, as well, to direct where those funds should flow.

Ms. PAPEZ. Absolutely. And it also undermines the constitutional authority the people count upon to have the Congress, as a body, decide where the money is going to go.

Ms. NOEM. What is interesting to me is that in fiscal year 2015 the Administration didn't even request the funds. You know, in 2014 they requested the funds; we denied those funds. But in 2015 they didn't even make the request. They just made the decision among themselves to go to this other fund and get the revenue that they needed.

Ms. PAPEZ. That is correct. And I think, to me, that points out another reason why—you know, that issue is—you know, it may not be an issue that goes to the courts. If it does, they can resolve it. If it doesn't and it isn't resolved in the courts, that is an issue that should come back to this body, in terms of perhaps legislative action or at least oversight action, to say, where is this happening? And this Subcommittee has done that.

Ms. NOEM. To put forward consequences.

Thank you. I appreciate your testimony.

I yield back.

Chairman ROSKAM. I would like to recognize our newest Member of the Subcommittee, Mr. Renacci.

Mr. RENACCI. Thank you, Mr. Chairman.

I want to thank the witnesses. I want to welcome you all, especially my fellow Buckeye, Mr. Adler.

I was going to stay away from the Supreme Court issue until Mr. Weiner brought it up and indicated that, you know, the exchanges, if the State didn't step in, that somehow this law said that the Federal Government could come in and step in. And it is amazing; I am looking at the statute here. It reads, "Where enrolled in through an exchange established by the State"—that seems pretty clear to me.

I was a businessman for 30 years before I came here. I was in the healthcare sector. I had to deal with a number of regulations. If I could not interpret "exchange established by the State," being that simple, I never knew, as a businessowner, I could go and just use discretion to move all around and make sure that I was able to do what I wanted to do versus what the law said.

Mr. Adler, it seems pretty clear, those words, "exchange established by the State." Do you agree?

Mr. ADLER. I certainly think they are clear.

Mr. RENACCI. I would think so.

Recently, Andy Grewal, a tax law professor at the University of Iowa, discovered other examples where the Administration has expanded the eligibility for these tax credits beyond the language of the statute.

Mr. Adler, can you discuss some of those?

Mr. ADLER. Yes, I can discuss them briefly. And I believe Professor Grewal is going to submit a written statement summarizing his research and a forthcoming article he has.

But he identified instances in which the IRS, in issuing regulations to implement section 36B of the Internal Revenue Code, expanded tax-credit eligibility both to individuals that fall outside the income requirements that are provided for in the statute as well as to provide tax-credit eligibility for some aliens that are unlawfully present in the country, contrary to the text of the statute.

And he further pointed out that, because of the way the statute is written and because tax-credit eligibility is the trigger for employer mandate penalties, the IRS' unilateral expansion of tax-credit eligibility carries with it an increase in the exposure of employers to potential penalties.

And he has written these up on the website of the *Yale Journal of Regulation* and has a forthcoming article that details how the IRS' regulations are expressly contrary to the plain text of the statute and that the IRS really offered no legal justification for those differences.

Mr. RENACCI. So, again, this hearing, as I always say, is not about the healthcare law; it is about the President's discretion. And there are some issues that are not in front of the Supreme Court, and that is one of the reasons we are having this hearing.

Mr. Weiner again used the word "discretion" multiple times, which really frustrates me, as someone who had to live within the rules as a businessman. How much discretion does this statute provide to the Treasury to set eligibility standards?

Mr. Adler, do you want to answer that?

Mr. ADLER. Well——

Mr. RENACCI. I already know what Mr. Weiner would say. He would say we have all kinds of discretion, the executive branch has discretion. Mr. Adler, you tell me what you believe.

Mr. ADLER. Well, I think there are certain aspects of eligibility that are very clear. So, for example, where the statute says that you must fall between 100 percent and 400 percent of the poverty line, 100 percent and 400 percent are pretty clear, right? Those involve numerical calculations, and you are either within that range or you are not.

There certainly are areas where the Administration has discretion in terms of how aggressively to enforce those provisions, whether to seek penalties, whether it wants to spend more time chasing after people that earn above those thresholds as opposed to below those thresholds. Those are the sorts of things that are typically the subject of executive discretion.

Trying to alter the thresholds, as the IRS has done, is not the sort of thing that has traditionally been recognized as permissible executive discretion.

Mr. RENACCI. Thank you.

And, lastly, I want to change subjects. Professor Adler, the State of Ohio, along with several public universities, has sued the Administration over being assessed a tax for the reinsurance program.

Can you explain why this is a problem and how it implicates the 10th Amendment?

Mr. ADLER. Sure.

So Attorney General Mike DeWine has filed this suit, and the basic claim is that insurance plans provided by State and local government entities are not covered by the plain text of the statute as entities that are subject to these taxes or payments, as some refer to them.

And it is traditional canon of construction of Federal statutes that they should not be read to impinge upon the traditional functions of State and local governments unless Congress has made that absolutely clear. And so the first argument that the State of Ohio is making is that, because the statute wasn't expressly clear that these fees or taxes should be imposed on State and local governments, it is impermissible for the Federal Government to seek to impose them.

And then a secondary claim is that, if the statute were to be read that way, whether or not it would raise 10th Amendment questions.

In my own work, I have primarily looked at the first issue, and I think the State of Ohio raises a very serious claim. There is, certainly, a large number of cases standing for the principle that you don't read a statute to infringe upon State prerogative or State functions unnecessarily. And it does not appear that there is clear—at least, I have not seen clear statutory language that would seem to authorize the imposition of these assessments on State and local governments.

And I believe that that case is currently pending in district court, and I believe motions for summary judgment and motions to dismiss have been filed.

Mr. RENACCI. So another possible overreach because of discretion.

Mr. ADLER. Sure. Sure.

And I would just say, just as we have seen litigation for decades under statutes like the 1990 Clean Air Act—which, you know, there was just a case in the D.C. Circuit a couple weeks ago on that, and there are more pending—there will be litigation under this statute for decades to come filed by States, by companies, by individuals. That is the way complex litigation is, especially when you are dealing with something as complex and as important as health care.

Mr. RENACCI. Thank you.

I yield back.

Chairman ROSKAM. Mr. Meehan.

Mr. MEEHAN. Thank you, Mr. Chairman.

There are so many places to jump in on this conversation.

Ms. Turner, we had discussed before, I think you commented a little bit, one of the questions was about the quality bonus payment demonstration project. And I am trying to get the boundaries of this discretion that apparently the President believes he has.

And this was a demonstration program in which some $8.3 billion was tied to a demonstration program which my colleague, Mr. Holding, identified as being one in which the entire United States was covered. So its scope, in and of itself, is unprecedented for a demonstration project; is that not accurate?

Ms. TURNER. That is correct, Congressman.

Mr. MEEHAN. And we also have budget neutrality requirements. Isn't that an aspect of OMB approval for these kinds of demonstration projects, budget neutrality?

Ms. TURNER. They certainly would not be allowed to spend money that is not appropriated by Congress legally.

Mr. MEEHAN. So what is the solution? Mr. Weiner seems to object to the idea that there is litigation associated with this. What is the solution when you see an interpretation—I was a former prosecutor, and I knew what prosecutorial discretion was, when we had a broad spectrum of rules before us, but we were limited in the resources to be able to use those rules, so we made the best use of the existing resources to interpret the existing laws.

This is a different situation, is it not, in which what we have is a disregard for the existing law and, under the guise of discretion, reinterpreting that law in a way that you want to see an outcome and, in fact, reinterpreting it in a way that we have established contravenes existing requirements such as budget neutrality.

Ms. TURNER. That has certainly been one of the great frustrations with this law. First of all, it is so complex that it is extraordinarily difficult to track all of the spending and all of the changes that are being made to this law.

But when you look at the authority of Congress, when the President takes an oath of office to faithfully execute the laws of the United States, that is part of the trust in the Administration, that they are not going to push the envelope so much, as they have with this law, that the Constitution doesn't really provide, other than through the courts, a way for you to have a recourse.

And, yes, as Mr. Rangel mentioned, the courts are a vehicle, but you cannot litigate hundreds of different challenges to this law.

Mr. MEEHAN. I think that point is so—Ms. Papez, you served as counsel in an agency in which you were responsible for interpreting the boundaries of what could and could not be done and, I am sure, many times gave advice that this was not doable.

And it has been said that, you know, the Court is an opportunity to resolve these issues. How realistic is it that the Supreme Court is going to be able to play the role of resolving these kinds of questions if it is not done—or how realistic is the Supreme Court going to be?

Ms. PAPEZ. Well, I think some of the Justices actually spoke to that at the hearing in March. I mean, they made clear that the Constitution limits their authority to resolve the particular provision or controversy in front of them.

And what the argument seemed to show, including arguments by the Administration and the Solicitor General, is that if the courts rule on the particular provision in front of them—in the King case, it is, you know, what does it mean to say an exchange established by the State; can that include the federally created exchanges? That may just open the door to a host of other questions that will then have to go back to the political branches. And I think members of the Court recognize they can't issue an advisory opinion addressing those issues.

So the point is it has to maybe come back to the Congress. At a minimum, it should be subject to legislative oversight, like the hearing today, to say, what would we do if the Supreme Court were to conclude that one provision is invalid? And that means the law doesn't work anymore? The Court, I think, has made clear on numerous occasions that is not its job to fix. That has to go back to the Congress.

Mr. MEEHAN. Mr. Weiner, what is the solution? How do you address this? What is our capacity to rein in when an Administration acts in direct contravention not only of the bounds of discretion but within the statute or the agency requirements itself that they meet certain budgetary requirements to be able to exercise that discretion but they act way beyond the scope of it? What is the solution?

Mr. WEINER. Well, the Congressional Research Service did a study on administrative discretion, and they talked about the hammers that the Congress has. Congress can pass legislation that says, if you miss a deadline, the following things happen. And with great specificity, Congress can, in fact, deal with situations where it does not agree with the actions taken by the executive branch.

Mr. MEEHAN. Such as the numerous occasions where laws have been passed in the House of Representatives and then disregarded because the President says, "If you do pass that, I will veto it?" What is the solution when the President says, "I have chosen to do this because I am saying it is my discretion, and you, Congress, if you do it, I will veto it?"

Mr. WEINER. Well, I think that is a failure when—if legislation is needed—and I am not sure I agree that it is—but if legislation is needed and the political process can't provide it, then I think that is a failure of the political process.

But it doesn't justify—I don't think it means we should go to litigation because I think we should try to resolve things——

Mr. MEEHAN. We have seen that litigation cannot be a solution because it is incapable of accommodating the vast number of challenges.

So the question is: Do we just say, "No big deal" and walk away and say, "Never mind?"

Mr. WEINER. No. I think you keep pushing the political process and try to get an answer there.

Mr. MEEHAN. Which is why we are having these hearings, isn't it? And I think that answers one of the questions of my friend, Mr. Crowley. Thank you.

Chairman ROSKAM. Mrs. Black.

Mrs. BLACK. Thank you, Mr. Chairman. I appreciate your allowing me to sit on this Committee and ask questions.

I do want to take a point of personal privilege. This is the National Foster Care shadowing week, and I do have a gentleman here with me from my district, Zach Grumman. He is from Jackson County, and he attends Tennessee Tech in the district. He is an English major. It is great to have him here with me.

Chairman ROSKAM. Welcome.

Mrs. BLACK. I want to go back to the publication by Professor Andy Grewal of the University of Iowa School of Law and the blog posts. And I would like to ask unanimous consent to submit this for the record.

Chairman ROSKAM. Without objection.

[The submission of The Honorable Diane Black follows:]

Yale Journal on Regulation

More Unlawful ACA Premium Tax Credits, by Andy Grewal

[REG-Notice and Comment - Tuesday, May 12, 2015]

I might be accused of picking at low-hanging fruit, but I'd nonetheless like to devote another blog post to more IRS regulations that expand and contradict Section 36B. My prior blog posts, which I've adapted into an essay upcoming in Bloomberg BNA, discuss regulations that improperly extend ACA premium tax credits to persons in the Medicare coverage gap and to some unlawful aliens. In this post, I want to highlight regulations that improperly penalize employers and that give credits to taxpayers already enrolled in employer-sponsored minimum essential coverage.

Broadly speaking, Section 36B offers premium tax credits, on a month-by-month basis, to taxpayers who purchase Exchange policies only when they can't otherwise obtain minimum essential coverage. However, the mere offering of minimum essential coverage by an employer to a taxpayer will not disqualify her from tax credits. Instead, the employer coverage must be affordable and provide minimum value. See Sections 36B(c)(2)(C)(i) & (ii).

Congress recognized that some taxpayers would enroll in minimum essential coverage through their employer, whether or not that coverage was affordable or provided minimum value. In these circumstances, Congress decided that premium tax credits should not be allowed. Why should the federal government subsidize a second set of health insurance coverage?

Section 36(c)(2)(C)(iii) consequently indicates that the employer affordability and value limitations "shall not apply if the employee . . . is covered under the eligible employer-sponsored plan." In proposed regulations, the IRS followed the statutory command and denied credits for a given month when a taxpayer was covered under an employer plan that offered minimum essential coverage. See Prop. Reg. 1.36B-2(c)(3)(vii), 76 F.R. 50942 (2011).

The IRS, however, eventually expanded the statute. Commenters worried that many employers automatically enrolled employees in coverage, and taxpayers might unwittingly find themselves with employer-sponsored minimum essential coverage for a given month, thereby disqualifying them from credits.

The final regulations address this and give credits to taxpayers when they are automatically enrolled in employer minimum essential coverage. In so doing, the IRS explicitly acknowledged that "Section 36B(c)(2)(C)(iii) and the proposed regulations provide that an individual who enrolls in an eligible

employer-sponsored plan is not eligible for the premium tax credit even if the plan is unaffordable or fails to offer minimum value." See 77 F.R. 30381 (2012) and Treas. Reg. 1.36B-2(c)(3)(vii)(B). In refreshingly candid terms, the IRS thus noted that its regulations contradicted the language of the law.

As a matter of abstract policy, the substance of the IRS's re-write seems somewhat reasonable. The problem is that it has no statutory basis. Congress plainly denied credits to taxpayers who actually receive health benefits from their employers. Nothing in Section 36B(c)(2)(C)(iii) allows the IRS to rewrite the law whenever it thinks that doing so is a good idea.

The IRS's re-write is especially problematic because it leads to further employer penalties under Section 4980H(b). Employers who offer minimum essential coverage generally don't face penalties unless an employee receives a credit under Section 36B. Under the language of Sections 36B and 4980H, employers will avoid penalties when minimum essential coverage is actually provided, because no credit is allowable in these circumstances. But the IRS regulation ignores this limitation and essentially demands a penalty from employers. This seem quite unfair.

As I hinted in the opening line of this post, the IRS's flippant approach to Section 36B is nothing new. However, taken together, the various IRS re-writes paint an odd picture. When one compares Section 36B to the IRS regulations, one does not see a legislative enactment with a complementing set of administrative regulations. Instead, when viewed together, Section 36B and the IRS regulations look more like a legislative proposal by one house of Congress and a counterproposal by another house. That is, the IRS has, in various circumstances, rewritten Section 36B to reflect the statute it believes should have been enacted, rather than that which was enacted. The IRS's aggressive approach will ensure continuing litigation over Section 36B, regardless of how *King v. Burwell* turns out.

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Mrs. BLACK. And as has already been said, the post details, those final regulations from the IRS on the eligibility for premium tax credits, we see the regulations give credits to taxpayers who are automatically enrolled in employer-sponsored minimum essential coverage even though the IRS, the IRS, has acknowledged that the individual is not eligible for the tax credits. It is unbelievable to me that that could be taking place.

Congress has explicitly denied these premium tax credits to individuals who are receiving health benefits from their employers. I am extremely concerned that this policy will lead to employer penalties. I have actually had employers call me and tell me they are concerned about this personally, about what this is going to mean to them.

They are trying to abide by the law. They are trying to meet all the regulations. Obviously, the regulations were late coming out. They were supposed to start with reporting mechanisms in January. They didn't get the final regulations until February. It is costly to them and so on.

Can any of you address the impact that you believe this will directly have on employers?

Ms. Turner, why don't I start with you.

Ms. TURNER. Employers have just, as I mentioned before, been run through the wringer in trying to comply with this law, and this is a relatively obscure provision that Professor Grewal has found, among several others, when he has looked at the statutory language and the significant conflict.

But employers are doing the right thing here in trying to provide coverage to their employees. They are following the law often with automatic enrollment. And if that happens and this person still goes to the exchange for coverage and if it is allowed because of this breach of the Federal rules, it puts the employer in an impossible position.

Even doing their best to comply with the law is not possible because the law is in conflict with itself and really shows the extraordinary difficulty of changing a law as you go along and the repercussions and the chain effect that that requires.

Mrs. BLACK. It is a huge concern. And it is apparent that this Administration does not have the capability of accurately verifying eligibility for these subsidies, and they have had repeated illegal workarounds on the law that have exacerbated this situation.

For instance, in the 2015 plan, the CMS implemented a policy that I believe is outside the bounds of the law, once again, where they automatically re-enrolled individuals into the exchange coverage even if they did not proactively select a new plan.

And in that they based their subsidies on income information that was out of date. They knew it was out of date. It was based on 2014 enrollment applications. And according to their own Office of Assistant Secretary for Planning and Analysis, nearly 2 million people were enrolled in coverage via this method that is going to potentially set up for not only a waste in taxpayer dollars, but also the issue of what it will do for the employers.

And, Ms. Papez, would you please address what you would say is the legality of what is happening with this automatic enrollment using numbers that are not verified. Is it legal? Do you believe that

this is something that would, if it were in a court of law, be seen as illegal?

Ms. PAPEZ. Well, I think the question goes to a point you raised, which is you would start with, you know, does the statute speak to this issue. And, to your point, if the statute speaks clearly to an issue, there is very little administrative discretion to depart from that. So I think that is the first point.

I think the second point is one we have discussed a little bit, which is, to the extent that the agency has discretion on implementation, there has to be an—and there are other statutes like the Administrative Procedures Act that speaks to this—there has to be a rigorous process for, you know, documenting, announcing, and justifying the manner in which particular programs are implemented, the way particular decisions are made.

And, you know, there are a number of APA cases, for example, in the Federal courts in D.C. here that take the position that, you know, if an agency action that affects real rights and real issues is based upon, you know, numbers or statistics or findings that are not actually verified and do not have an appropriate factual basis in the administrative record, then they are void as a matter of law and the agency has to go back to the drawing board.

Mrs. BLACK. Thank you.

And, Mr. Chairman, I want to thank you for having this hearing today because it is our responsibility to oversee the administrative policies and the lack of following the law. And I applaud you for allowing us to bring this forward.

Chairman ROSKAM. Thank you.

Ms. Turner, I am sensitive to your time. So I know you have a flight to catch. If you need to catch that flight and walk off quietly, we will avoid eye contact and let you go. And we are gratified in advance for your time and attention today. So we are all supersensitive to that dynamic.

Ms. TURNER. Thank you, sir.

Chairman ROSKAM. So, Mr. Weiner, the phone lines have lit up. Everybody's interested in your response.

So earlier Ms. Turner made this assertion, and she said, "Look, you know, Congress has dealt with this 17 times." And if you look at her list that was prepared by the Galen Institute, you know, they are all enumerated. They have to do with military benefits, VA benefits, drug price clarification, doc fix tax, extending the adoption credit, TRICARE for adult children. It goes on and on and on.

And what is interesting is, you know, she lists them chronologically. So, at first glance, you can say, "Well, look. It was with the old majority, and the old majority came in and did a lot of cleanup."

But the story gets more interesting when you say, "Oh. This is after there was a new majority." In fact, a majority of these took place after there was a Republican majority.

So, in light of that, would you want to revisit and reconsider your characterization of this institution being dysfunctional and incapable of dealing with the Affordable Care Act?

And, if you choose not to re-characterize it, how would you characterize those legislative changes that went through the House, the Senate, and were signed into law by President Obama?

Mr. WEINER. Well, thank you for the opportunity to discuss this further.

I don't retreat from the statement. I think that, when you look at the Affordable Care Act and—not just the Affordable Care Act, but that is what we are focusing on—the question is whether Congress has been able and expected to be able to address the important issues.

Many of the issues on this list are important, but they are not core to the issues that are at stake, the principal issues that are dividing the parties, the legislature——

Chairman ROSKAM. Okay. So just in the interest of time, you are dismissive of the past accomplishments. Your argument is that they are de minimis. My argument is that they are more significant than that. Is that fair enough?

Mr. WEINER. Well, I think it goes beyond that. The question is what is it that hasn't been done. The King case, that is the kind of issue that in past years would have been resolved with a technical amendment. It should never have gotten to this stage.

The employer mandate that Ms. Turner cited, yes, there was a bill passed. It had a poison pill in it, in my view, and it didn't get past the Senate. That doesn't prove that we are able to deal at this stage.

I think we will reach a point where we are able to deal with it. My only argument is that I am not worried about the precedence because I think we are going to be able to come together at some point and do a better job than——

Chairman ROSKAM. So go back to my opening statement. And I appreciate what you are saying. But go back to my opening statement.

And that is I put a provocative statement out there, and the provocation was: Do the votes of the American public matter? Do they matter at all?

So the ACA was enacted. The majority changed. Political scientists can make their decisions about what the reasons were for the change in the majority, but I think most folks say that the Affordable Care Act was largely the discussion point in the 2010 election.

The majority changes. And so you have a new, new, Congress that is reflecting who? The American public, who is what this is all about.

And so you see this conundrum then and this sort of—I would argue that you are making a false choice and you are saying, well, if Congress chooses not to deal with the things that we say—that we deem are important, that is the architects of the statute, then somehow Congress is dysfunctional.

So your point is—I understand your point. You understand my point. Let's move on.

So on page 4 of your testimony—it is interesting. You have a number of footnotes throughout. You have 17 footnotes in your testimony. On page 4 of your testimony you make an assertion, and

I will let you catch up. I will read it to you while you are catching up.

You say, "The postponement, in fact, was well within the historical bounds of administrative discretion as a transitional phase-in of a new requirement."

Now, there is no footnote there. There is an assertion there. What is the proof of that statement?

Mr. WEINER. Well, I think the proof of the statement is it goes on and talks about, for example, the statement of the former HHS Secretary in the Bush Administration who wrote an article after the employer mandate was postponed and said that he thought it was wise and that he thought it was consistent with the kinds of things that were done with Medicare Part D.

Chairman ROSKAM. Okay. But that is a different argument, isn't it, than the one that Professor Adler was making?

And, Professor Adler, your argument is this is different in terms of breadth and scope, and you made this point about taxes. So give us a little more color commentary, if you would, on this tax question and these postponement questions.

And answer this: If there is a future Administration that says, for example, "We don't think that the international tax regime is working for our country. We think that it creates a disadvantage for American companies to be taxed on their worldwide operations, and we are choosing not to assert or collect or"—pick your verb—"but we are not going to go after and collect that tax," is that possible under this line of thinking? I would think that it is.

Mr. ADLER. Well, I think it is certainly concerning. In my testimony, I quote my friend Nicholas Bagley at the University of Michigan, who I disagree with quite strongly on a wide number of issues, including *King* v. *Burwell*, but——

Chairman ROSKAM. So just for the point, this professor that you are citing is a proponent of the ACA. Is that right?

Mr. ADLER. He is a proponent of the ACA. He and I have practically gone around the country debating *King* v. *Burwell*. But he has written an article identifying, I think, five instances, including the employer mandate delays, where he does not believe—and I certainly don't believe—the delays can be justified under traditional administrative discretion.

And just to put this in a context to make that clear, if you think about the ways in which Congress can force action or force a change in the law, one of the traditional things Congress does is to write a law that says that private parties are subject to certain legal obligations as of a date certain.

In environmental law, this happens all the time. An emitter must control emissions by X date. That is separate and apart from what the agency or the executive branch might do to enforce that obligation.

So here, with the employer mandate, the statute says that this obligation and what the Administration claims is a tax liability is imposed upon private entities as of a date certain. The Administration certainly has transition authority to say, "It might be hard to comply with this at first; so, we will give you a little extra time before you send us the check" or, "We are not going to seek penalties because it is going to take a while to get the reporting require-

ments in place." And certainly there are lots of examples of that sort of transition relief.

What the Administration did here that is different is they didn't merely say, "We are going to give you more time. We are not going to seek penalties." They said, "The tax liability that is written into the law that is directly imposed on private parties"—so this isn't a delegation to the agency, saying, "Agency go enforce it." This is directly imposed by Congress on private parties—the IRS said, "We are going to waive that entirely for a calendar year." It then said, "We are going to make up new categories and waive it selectively for some as opposed to others."

And that is the sort of thing that none of the precedents that the Treasury Department identified——

Chairman ROSKAM. That is new ground. That is ground upon which a future Administration could do the very thing that I just described.

Mr. ADLER. It is certainly something that concerns me. And I should just note for the record, you know, we have seen things I don't think are quite as egregious, but are of this character in the past. And I have certainly been critical of them.

In the last Presidential election, as a candidate, Governor Romney made some claims about plans to waive certain aspects of this law, and I, among others, said, "Hey, look. That might be a good idea, but the President can't do that. And it will be important, whomever the next President is, that they not be allowed to build upon this precedent to waive statutory obligations that are imposed directly upon private parties because that is simply not the sort of authority that the executive branch has unless Congress confers it upon the executive branch."

Chairman ROSKAM. So, Ms. Papez, you were talking a bit about the nature of the litigation and the lack of capacity of the court to bring certain remedies.

So, for a layman, that is sort of a red light-green light game, right, where the court can say, "No, you can't do this" and, "Yes, you can do that?"

So can you describe some of those natural limitations from a litigation point of view and how important it is that those sorts of decisions are made here in Congress as opposed to somewhere else?

Ms. PAPEZ. Sure. You know, the limit comes from the constitution itself. Article III says the courts can only resolve what are called justiciable cases in controversy. So there has to be a specific legal question presented that has a real effect on the parties in front of the court.

Chairman ROSKAM. Right. It is not a hypothetical and so forth.

Ms. PAPEZ. No.

Chairman ROSKAM. There has to be a matter in controversy.

Ms. PAPEZ. Right. A matter in controversy between the parties who are in front of the court. And Article III says the court can resolve that controversy.

Now, what we heard in the King case, including from the Administration's representative, the Solicitor General, is that, if the court resolves the controversy presented in that lawsuit, which is, "How do you interpret 'established by a State?'"—that is the phrase at issue—that, if the court interprets that the way it appears to be

written, which means "State" is a State, not a federally created exchange, that there are going to be all these consequences to the law.

And, to your point, that is exactly where the Constitution contemplates that the courts stop and Congress steps in. And several justices made this point at the argument. They said, "Look. Our ability to indulge that sort of argument, whether you are right or whether it is good policy or whether there are practical reasons not to interpret it this way because it will break some other portion of the statute, those are policy arguments. We are not speaking to whether they are right or wrong. We are saying the court can't do that. The court can't go that far."

And so that is where the issue would have to come back to the Congress. And the reason it has to come back to the Congress is because, where you are dealing with the appropriation of funds for Federal programs and when you are dealing with the architecture of a statute that originated in this body, there is a limit in the Constitution as to how much the executive branch can do to fix or change or adjust that in response to new circumstances. It has to come back to this body.

Chairman ROSKAM. So I couldn't have done it better myself. But Mr. Rangel at the beginning of the hearing said, "Look, what is this all about? And why are we here?" And he asked a question that I think is a fair question. And that is, "With so many things going on in our country and so many things going on in the Congress, is this worthy of our time today?"

And I would argue that this discussion and the level and the breadth and the depth of this discussion is worthy of our time.

And for each of the witnesses, you have been forthright and you have focused in not on the things that we disagree about, that is, the merits of the Affordable Care Act, which are obviously a wide range of opinions on this Committee, but how we get in and around sort of this core issue.

So, Mr. Weiner, you have demonstrated, you know, a higher tolerance for executive discretion than I would, obviously, or than the other witnesses have, but you can see how this question really does bring us together. Because it is the ACA today. It can be international tax tomorrow. It can be an environmental question the next day. So when Mr. Rangel said this is about Presidents past and future, it absolutely is.

And so, you know, in closing, the point I want to make is that we have an obligation as a Committee, based on the House rules, to do the oversight work that I described in my opening statement. We also have an obligation, at least I feel one, to fill in the void of silence. Because I would argue that silence is assent. Silence creates precedent. Silence creates license over a period of time.

And so what we are doing today is we are putting not just this Administration, but future Administrations, on notice that Congress has a high expectation, that Congress will do the law writing, and we have an expectation that the executive branch will execute those laws.

And I want to thank all of my Members today on both sides of the aisle. You have been very generous, you experts, with your time and your attention.

And, with that, the Committee——

Mr. RANGEL. Mr. Chairman.

Chairman ROSKAM. Yes, sir.

Mr. RANGEL. I just want to thank you for your generous explanation as to why we are here and to join with you in any expansion of legislative oversight to end abuse by any executive branch of government, regardless of who the President is.

And, also, I want to thank you for not going into the merits as to whether or not every American is entitled to access to health care or preconditions or whether or not to have the extensions.

And it is really pleasant to know that the things that I have a passion about were not objected to, but the conduct of the executive branch should always be a thing that the Congress should protect with its constitutional authority.

And so, as an American, I feel good walking away from this hearing knowing that, if this is a test as to what is constitutional, let me join in it, no matter which side I am on.

Because if the President was overzealous in providing health care to millions of Americans, he should learn by doing that as long as we succeed in doing it.

Chairman ROSKAM. We will leave it there. Thank you all.

The Committee is adjourned.

[Whereupon, at 11:58 a.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

Michael McConnell: Obama Suspends the Law

Like King James II, the president decides not to enforce laws he doesn't like. That's an abuse of power.

By MICHAEL W. MCCONNELL
Wall Street Journal
July 8, 2013 7:28 p.m. ET

President Obama's decision last week to suspend the employer mandate of the Affordable Care Act may be welcome relief to businesses affected by this provision, but it raises grave concerns about his understanding of the role of the executive in our system of government.

Article II, Section 3, of the Constitution states that the president "shall take Care that the Laws be faithfully executed." This is a duty, not a discretionary power. While the president does have substantial discretion about how to enforce a law, he has no discretion about whether to do so.

This matter—the limits of executive power—has deep historical roots. During the period of royal absolutism, English monarchs asserted a right to dispense with parliamentary statutes they disliked. King James II's use of the prerogative was a key grievance that lead to the Glorious Revolution of 1688. The very first provision of the English Bill of Rights of 1689—the most important precursor to the U.S. Constitution—declared that "the pretended power of suspending of laws, or the execution of laws, by regal authority, without consent of parliament, is illegal."

To make sure that American presidents could not resurrect a similar prerogative, the Framers of the Constitution made the faithful enforcement of the law a constitutional duty.

The Justice Department's Office of Legal Counsel, which advises the president on legal and constitutional issues, has repeatedly opined that the president may decline to enforce laws he believes are unconstitutional. But these opinions have always insisted that the president has no authority, as one such memo put it in 1990, to "refuse to enforce a statute he opposes for policy reasons."

Attorneys general under Presidents Carter, Reagan, both Bushes and Clinton all agreed on this point. With the exception of Richard Nixon, whose refusals to spend money appropriated by Congress were struck down by the courts, no prior president has claimed the power to negate a law that is concededly constitutional.

In 1998, the Supreme Court struck down a congressional grant of line-item veto authority to the president to cancel spending items in appropriations. The reason? The

only constitutional power the president has to suspend or repeal statutes is to veto a bill or propose new legislation. Writing for the court in Clinton v. City of New York, Justice John Paul Stevens noted: "There is no provision in the Constitution that authorizes the president to enact, to amend, or to repeal statutes."

The employer mandate in the Affordable Care Act contains no provision allowing the president to suspend, delay or repeal it. Section 1513(d) states in no uncertain terms that "The amendments made by this section shall apply to months beginning after December 31, 2013." Imagine the outcry if Mitt Romney had been elected president and simply refused to enforce the whole of ObamaCare.

This is not the first time Mr. Obama has suspended the operation of statutes by executive decree, but it is the most barefaced. In June of last year, for example, the administration stopped initiating deportation proceedings against some 800,000 illegal immigrants who came to the U.S. before age 16, lived here at least five years, and met a variety of other criteria. This was after Congress refused to enact the Dream Act, which would have allowed these individuals to stay in accordance with these conditions. Earlier in 2012, the president effectively replaced congressional requirements governing state compliance under the No Child Left Behind Act with new ones crafted by his administration.

The president defended his suspension of the immigration laws as an exercise of prosecutorial discretion. He defended his amending of No Child Left Behind as an exercise of authority in the statute to waive certain requirements. The administration has yet to offer a legal justification for last week's suspension of the employer mandate.

Republican opponents of ObamaCare might say that the suspension of the employer mandate is such good policy that there's no need to worry about constitutionality. But if the president can dispense with laws, and parts of laws, when he disagrees with them, the implications for constitutional government are dire.

Democrats too may acquiesce in Mr. Obama's action, as they have his other aggressive assertions of executive power. Yet what will they say when a Republican president decides that the tax rate on capital gains is a drag on economic growth and instructs the IRS not to enforce it?

And what of immigration reform? Why bother debating the details of a compromise if future presidents will feel free to disregard those parts of the statute that they don't like?

The courts cannot be counted on to intervene in cases like this. As the Supreme Court recently held in Hollingsworth v. Perry, the same-sex marriage case involving California's Proposition 8, private citizens do not have standing in court to challenge the executive's refusal to enforce laws, unless they have a personal stake in the matter. If a president declines to enforce tax laws, immigration laws, or restrictions on spending—to name a few plausible examples—it is very likely that no one will have standing to sue.

Of all the stretches of executive power Americans have seen in the past few years, the president's unilateral suspension of statutes may have the most disturbing long-term effects. As the Supreme Court said long ago (Kendall v. United States, 1838), allowing

the president to refuse to enforce statutes passed by Congress "would be clothing the president with a power to control the legislation of congress, and paralyze the administration of justice."

Mr. McConnell, a former judge on the U.S. Court of Appeals for the Tenth Circuit, is a professor of law and director of the Constitutional Law Center at Stanford Law School and a senior fellow at the Hoover Institution.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

The State of Ohio;
Warren County, Ohio;
The Ohio Department of Administrative Services;
The University of Akron;
Shawnee State University;
Bowling Green State University; and
Youngstown State University,
Plaintiffs,
v.
United States of America;
United States Department of Health and Human Services;
and The Honorable Sylvia Mathews Burwell in her official capacity as Secretary of Health and Human Services,
Defendants.

Civil Action
Case No. _____

COMPLAINT

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INTRODUCTION AND SUMMARY

1. This case involves an unprecedented assertion of power by the executive branch of the federal government to levy broad tax assessments directly against State and local governments and their instrumentalities. The assertion of this taxing power by the federal bureaucracy is inconsistent both with the text of the statutes upon which Defendants purport to rely and with structural protections of our federal republic embodied in the United States Constitution.

2. Invoking "Transitional Reinsurance Program" provisions of the federal Patient Protection and Affordable Care Act of 2010, the federal government has assessed and now collected mandatory monetary "contributions" not only from insurance companies and certain private self-insured health care plans, but also directly from State and local governments that provide self-insured health care plans for their employees.

3. Such taxes are illegal and unconstitutional as applied against the States and their instrumentalities.

4. Congress nowhere provided for these taxes to apply against the States and their instrumentalities. The federal bureaucracy overreaches and acts beyond its statutory authority in purporting to apply these taxes to Plaintiff the State of Ohio and its instrumentalities including the Ohio Department of Administrative Services, plaintiff universities, and Warren County.

5. Indeed, Congress explicitly limited application of these taxes to "health insurance issuers" and to "third party administrators on behalf of group health plans" as defined with reference to ERISA employee welfare benefit plans. For tax purposes, neither of those phrases comprehends States, local governments or their instrumentalities, and neither phrase suggests

that the federal government intended to levy these taxes on State or local governments or their instrumentalities.

6. Congress had good reason not to authorize such direct taxation of the States and their instrumentalities. Such taxation would alter radically the balance of authority between the federal government and the States: it would violate important federalism protections of the United States Constitution, including the Tenth Amendment and the related Anti-Commandeering doctrine and the doctrine of Intergovernmental Tax Immunity. Our Constitution does not permit the federal government to blur accountability for its programs or to conscript the States or local governments into the roles of federal tax assessor and federal tax collector.

7. The federal government through the United States Department of Health and Human Services has announced its intention to continue to assess and collect these mandatory tax "contributions" from State and local government entities through the year 2017.

8. The federal government has acknowledged, moreover, that a significant percentage of the monies so collected will not fund "transitional reinsurance," but instead will be directed into the general fund of the United States Treasury.

9. Thus, not only is the federal government purporting to tax the States and their instrumentalities directly, but it is doing so in part to fund federal programs unrelated to the specified objects of the tax and its central stated purpose.

10. Plaintiffs protested the stated intent of the federal government to collect these taxes from State and local governments, but the federal government has persisted in its illegal course and now has taken control of millions of dollars from the State of Ohio and its

instrumentalities including the Department of Administrative Services, plaintiff universities, and Warren County in the name of the federal Transitional Reinsurance Program.

11. As outlined more specifically below, Plaintiffs bring this action to recoup the tax monies thus wrongfully taken from them and to gain such further relief as is appropriate given the federal government's lack of legal authority to impose these taxes on the State of Ohio and its instrumentalities.

JURISDICTION AND VENUE

12. This Court has jurisdiction over the action under 28 U.S.C. §§ 1331, 1346(a)(1).

13. Venue is proper in this Court under 28 U.S.C. §§ 1391(e)(1)(C), 1402(a)(1).

PARTIES

14. Plaintiff the State of Ohio is a State of the United States. The State of Ohio maintains self-insured group health care plans for State employees, who are instrumental in the necessary and constitutionally required operations of State government. These State plans are not taxable "group health plans" as defined under the statutory language of the Transitional Reinsurance Program.

15. Plaintiff the Ohio Department of Administrative Services is a Department of the State of Ohio and among other duties is required by State law to direct and manage for State agencies risk management and insurance programs as authorized by the State, including the self-insured group health plan that it operates for State employees (which is not a taxable "group health plan" as defined under the statutory language of the Transitional Reinsurance Program).

16. Plaintiff Warren County is a political subdivision of the State of Ohio, and is one of 88 counties within the State. Warren County is authorized by Ohio statute to establish and maintain a self-insured group health care plan for its officers and employees, which it has done

in a plan that is not a taxable "group health plan" as defined under the statutory language of the Transitional Reinsurance Program.

17. Plaintiff the University of Akron is a public university and is an instrumentality of the State of Ohio as part of the State's university system. Consistent with Ohio law, it has established and maintains a self-insured group health care plan for its employees. That plan is not a taxable "group health plan" as defined under the statutory language of the Transitional Reinsurance Program.

18. Plaintiff Shawnee State University is a public university and is an instrumentality of the State of Ohio as part of the State's university system. Consistent with Ohio law, it has established and maintains a self-insured group health care plan for its employees. That plan is not a taxable "group health plan" as defined under the statutory language of the Transitional Reinsurance Program.

19. Plaintiff Bowling Green State University is a public university and is an instrumentality of the State of Ohio as part of the State's university system. Consistent with Ohio law, it has established and maintains a self-insured group health care plan for its employees. That plan is not a taxable "group health plan" as defined under the statutory language of the Transitional Reinsurance Program.

20. Plaintiff Youngstown State University is a public university and is an instrumentality of the State of Ohio as part of the State's university system. Consistent with Ohio law, it has established and maintains a self-insured group health care plan for its employees. That plan is not a taxable "group health plan" as defined under the statutory language of the Transitional Reinsurance Program.

21. Defendant the United States of America is the federal government within our constitutional republic as established, empowered, and limited by the United States Constitution.

22. Defendant the U.S. Department of Health and Human Services ("HHS") is an executive agency of the United States and has promulgated regulations purporting to relate to the Transitional Reinsurance Program under the Patient Protection and Affordable Care Act of 2010.

23. Defendant the Honorable Sylvia Mathews Burwell is the Secretary of HHS and as such is responsible for overseeing, directing, and enforcing Defendants' practices challenged in this action. She is sued in that official capacity.

BACKGROUND

A. The Transitional Reinsurance Program

24. Among the many measures contained in the federal Patient Protection and Affordable Care Act of 2010 ("the Act") are provisions relating to the "Transitional Reinsurance Program" that the Act requires be established by the States or by the federal government for States that elect not to create such a structure. *See* 42 U.S.C. §§ 18041, 18061.

25. HHS has reported that, at least as of the beginning of last year, "Connecticut is the only State that elected to operate a transitional reinsurance program." 79 Fed. Reg. 13752 (Mar. 11, 2014).

26. Ohio did not elect to establish a transitional reinsurance program.

27. Under 42 U.S.C. § 18061 as amplified by 42 U.S.C. § 18041, each State is required to establish or have the Secretary of HHS implement a "transitional reinsurance program" under which "health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments" for a three-year period beginning in 2014.

28. The program is to be designed so that "the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business …." 42 U.S.C. § 18061(b)(3)(B).

29. Nationally, the "aggregate contribution amounts" assessed under the program are to total $25 billion for the three year period covering 2014-2016. 42 U.S.C. § 18061(b)(3)(B)(iii), (iv).

30. Of that $25 billion, the statute requires that $5 billion "shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section." 42 U.S.C. § 18061(b)(4).

31. The Secretary of HHS has promulgated regulations purporting to implement the transitional reinsurance program. *See, e.g.*, 45 C.F.R. Part 153, also referencing definitions at 45 C.F.R. §§ 144.103, 146.145(a).

32. A "Contributing entity" required to make mandatory "contribution" payments is defined by HHS to mean a "health insurance issuer," or, "for the 2014 benefit year, a self-insured group health plan … whether or not it uses a third party administrator; and for the 2015 and 2016 benefit years, a self-insured group health plan … that uses a third party administrator in connection with claims processing or adjudication …." 45 C.F.R. § 153.20.

33. Thus, the HHS definition of "contributing entity" with regard to self-insured group health plans is contemplated to change from one year to the next, even though the statutory regime on which HHS purports to base its regulations has remained unaltered.

34. Consistent with the statute, the regulations make clear that a "health insurance issuer" means an insurance company, insurance service, or insurance organization licensed in a

State and subject to State law regulating insurance within the meaning of section 514(b)(2) of ERISA, and that the term "does not include a group health plan." 45 C.F.R. § 144.103.

35. Plaintiffs the State of Ohio, Warren County, the Ohio Department of Administrative Services, The University of Akron, Shawnee State University, Bowling Green State University, and Youngstown State University are not "health insurance issuers" within the terms of the governing statute or the HHS regulations promulgated thereunder, and they do not maintain a "commercial book of business" as issuers.

36. The Act nowhere explicitly defines "group health plans" potentially subject to the reinsurance tax as including self-insured government employee health plans operated by a State or its instrumentalities.

37. Rather, through a series of definitions that do not explicitly refer to State or local governments, the Act defines "group health plan" to mean "an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care ... directly or through insurance ...." 42 U.S.C. § 300gg-91(a)(1), as referenced by 42 U.S.C. § 18111.

38. The referenced ERISA section defines an "employee welfare benefit plan" to mean a plan "maintained by an employer." 29 U.S.C. § 1002(1). ERISA defines "employer," in turn, to mean a "person" acting in that capacity. *Id.* § 1002(5). And ERISA then defines "person" to mean "an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization," *Id.* § 1002(9). State and local governments are not listed as "persons" for this purpose. Indeed, there is a separate definition for them. *Id.* § 1002(10).

39. Self-insured group health plans operated for government officers and employees by States and their instrumentalities are not included within any "group health plans" required by the Act to pay "contributions" under the transitional reinsurance program.

40. Plaintiffs the State of Ohio, Warren County, the Ohio Department of Administrative Services, The University of Akron, Shawnee State University, Bowling Green State University, and Youngstown State University are not subject to a "contribution" assessment under the terms of the congressional enactment ordaining the transitional reinsurance program.

41. For coverage in 2014, HHS has required that what it deems "contributing entities" must pay $63.00 per "covered life" – that is, for each individual covered under a designated health plan – with those 2014 payments due at least in part by January 15, 2015.

42. HHS further has specified that "[o]f the $63 annual per capita contribution rate, $52.50 would be allocated" by the federal government "towards reinsurance payments and $10.50 towards payments to the U.S. Treasury."

43. HHS has announced that other such "contributions" will be required for plan coverage in 2015 and 2016.

44. HHS has enforcement authority with regard to the establishment of the transitional reinsurance program and purports to have the authority to impose substantial penalties for non-payment of the "contributions" that it requires.

45. The mandatory "contribution" that HHS requires of "contributing entities" is an enforced contribution to provide for the support of government, produces revenue for the government, and constitutes a tax.

46. Through its Centers for Medicare and Medicaid Services, HHS further has specified "[w]ho contributes?" under its reading of the program by stating: "All health insurance issuers, and self-insured health plans or third party administrators (on behalf of self-insured health plans or issuers) will contribute funds." See https://www.cms.gov/CCIIO/Resources/Presentations/Downloads/hie-reinsurance-fact-sheet-handout.pdf (last visited January 25, 2015).

B. Illegal application of the tax to the State of Ohio and its instrumentalities

47. As recited above, the statutory language establishing the requirements of the transitional reinsurance program does not include self-insured group health plans of States or their instrumentalities as among the entities required to pay the transitional reinsurance tax.

48. Congress nowhere explicitly has stated that this tax is to apply against the States and their instrumentalities.

49. Nonetheless, Defendants have taken the position that self-insured group health plans operated by States and their instrumentalities are subject to the mandatory transitional reinsurance tax assessments.

50. By letter of November 18, 2014, the Warren County, Ohio Board of County Commissioners wrote to the HHS Administrator of the Centers for Medicare & Medicaid Services, with a copy to Defendant HHS Secretary Burwell, recording a protest and reservation of rights expressing "significant concerns regarding the federal government's imposition of the transitional reinsurance program against state and local governments," while noting that the Board would proceed with on-line payment of the taxes under such protest.

51. To date, the Warren County Commissioners have received no response to their letter apart from Defendants' actions to process the disputed taxes.

52. Then, by letter emailed and mailed January 8, 2015, Ohio Attorney General Mike DeWine, in his capacity as chief law officer and litigation counsel for the State of Ohio and its officers and departments, advised Defendants Burwell and HHS that the transitional reinsurance tax does not by statute and constitutionally cannot apply against State and local governments that operate self-insured group health care programs to care for government employees.

53. Attorney General DeWine's letter also asked Defendants to take no further action to process these assessments or to take control of or retain monies made available by the State or its departments under such protest and pursuant to federal demand.

54. That letter from Attorney General DeWine to Defendants invited Defendants to communicate with his office on the issue, and asked that Defendants advise the State if Defendants do not purport to apply these taxes directly against the States and their instrumentalities. And it made a demand for return of any and all monies taxed from the State and its State entities in the name of the transitional reinsurance program.

55. To date, Defendants have responded to that letter only by proceeding to collect the disputed taxes from the State of Ohio and its instrumentalities.

56. Defendants have collected transitional reinsurance tax payments from the State of Ohio and various of its instrumentalities including the Ohio Department of Administrative Services, plaintiff universities, and Warren County.

57. For example, on or about January 15, 2015, Defendants or their agents collected or otherwise took control of a "payment amount" of $5,389,020.00 from the State of Ohio through the Ohio Department of Administrative Services, allocated by Defendants as being the sum of $4,490,850.00 (as the "contribution rate for program payments and program

administration funds") and $898,170.00 (as the "contribution amount due for general fund of the United States Treasury").

58. That tax was imposed on the basis of a "gross annual enrollment count" of 85,540 "covered lives" – that is, of employees or their dependents covered by the Ohio self-insured plan operated for State of Ohio employees by the Ohio Department of Administrative Services, as then multiplied by what Defendants call the "total applicable benefit year contribution rate" for 2014 of $63.00 per covered individual.

59. Plaintiffs are informed and believe that Defendants have proceeded to collect other transitional reinsurance tax "contributions" from other entities of the government of the State of Ohio.

60. For example, on or about January 12, 2015, Defendants collected or otherwise took control of a "payment amount" of $325,584.00 from the University of Akron (allocated by Defendants as being the sum of $271,320.00 as the "contribution amount due for program payments and program administration funds" and $54,264.00 as the "contribution amount due for General Fund of the US Treasury").

61. On or about January 14, 2015, Defendants collected or otherwise took control of $56,007.00 from Shawnee State University (allocated by Defendants as being the sum of $46,672.50 as the "contribution amount due for program payments and program administration funds" and $9,334.50 as the "contribution amount due for General Fund of the US Treasury").

62. On or about January 15, 2015, Defendants collected or otherwise took control of a "payment amount" of $275,247.00 from Bowling Green State University purportedly pursuant to the Transitional Reinsurance Program.

63. On or about January 15, 2015, Defendants collected or otherwise took control of a "payment amount" of $108,517.50 from Youngstown State University as the "contribution amount due for program payments and program administration funds." Plaintiffs are informed and believe that Defendants propose and intend to take an additional $21,703.50 from Youngstown State University on or about November 13, 2015 as the "contribution amount due for general fund of the United States" (again to use the phraseology of Defendant federal authorities.

64. Defendants also have collected or otherwise taken control of transitional reinsurance tax payments from units of local government within the State of Ohio.

65. For example, on or about January 15, 2015, Defendants collected or otherwise took control of a "payment amount" of $94,710.00 from Warren County, Ohio. That amount is said to be Warren County's 2014 "contribution rate for program payments and program administration funds."

66. Plaintiffs are informed and believe that Defendants propose and intend to take an additional $18,942.00 from Warren County on or about November 13, 2015 as the "contribution amount due for general fund of the United States" (again to use the phraseology of the federal authorities).

67. Although Defendants wrongfully have deprived the State of Ohio and its instrumentalities of these and other funds pursuant to Defendants' improper and unconstitutional misreading of the transitional reinsurance program, Defendants to date have refused to return such monies and have not returned these monies to Plaintiffs.

C. Imposition of this tax against the State of Ohio and its instrumentalities is contrary to law and violates the Constitution of the United States.

68. The Congress of the United States did not intend to impose this tax on the States or their instrumentalities.

69. The text of the statute creating the transitional reinsurance program does not authorize applying the tax against States or local governments.

70. Indeed, the Congressional Budget Office of the Congress of the United States has expressed its understanding that: "Under the reinsurance program, ... the government will collect [in addition to the $5 billion to be deposited into the general fund of the United States Treasury] $10 billion in 2015, $6 billion in 2016, and $4 billion in 2017 (for insurance issued in 2014, 2015, and 2016) through a per-enrollee assessment on most *private* insurance plans, including self-insured plans and plans that are offered in the large-group market." CBO, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014*, at 7 (April 2014) (emphasis added).

71. Had Congress applied this tax directly against State and local governments, which it did not, such a tax would violate the "residuary and inviolable sovereignty" that the United States Constitution leaves to the several States under our federalist system (to use the words of *Federalist No. 39* as quoted, for example, in *New York v. United States*, 505 U.S. 144, 188 (1992)).

72. Especially here, where the tax is not imposed as a "user fee" on States or local governments and where the tax is specifically designed to raise more in revenue for the federal government than will be allocated to the reinsurance program (with certain amounts of the tax revenues indeed designated as monies that "may not be used for the program established under

this section." 42 U.S.C. § 18061(b)(4)), such a direct tax against the State and its instrumentalities would breach our federal Constitution's vertical separation of powers.

73. The federal government lacks authority under the United States Constitution to levy such broad-based, revenue-generating taxes against the States and their instrumentalities.

74. Plaintiffs are aware of no precedent in the history of our Republic under which such a wide-sweeping tax scheme has been imposed by the federal government directly against the several States and their instrumentalities.

75. Defendants' effort to impose this tax against the State and local government Plaintiffs is precluded by the structures of the United States Constitution, including the Tenth Amendment, and violates the related constitutional doctrine of Intergovernmental Tax Immunity and the Anti-Commandeering doctrine.

CLAIMS

COUNT 1

(Claim against the United States for the recovery of illegally or erroneously assessed or collected tax)

76. Plaintiffs restate and reallege each of the statements and allegations set forth in paragraphs 1 – 75 above.

77. The Congress of the United States has authorized initiation of civil action in this Court against the United States for the recovery of any internal revenue tax that has been erroneously or illegally assessed or collected, and has waived any defense of sovereign immunity to such action. 28 U.S.C. § 1346(a)(1).

78. The taxes assessed against and collected from Plaintiffs under the claimed authority of the transitional reinsurance program are tax revenues generated within the boundaries of the United States that have been assessed, collected, or retained erroneously.

79. Principles of statutory and constitutional law and equity require the United States to refund this money to Plaintiffs.

COUNT 2

(Claim against all Defendants under the federal Administrative Procedure Act)

80. Plaintiffs restate and reallege each of the statements and allegations set forth in paragraphs 1-79 above.

81. The Congress of the United States has authorized this Court in such matters to "decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action." 5 U.S.C. § 706.

82. Congress further has specified that a "person suffering legal wrong because of agency action … is entitled to judicial review thereof," has waived sovereign immunity as to claims brought under the Administrative Procedure Act, and has provided that "[t]he United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States …." 5 U.S.C. § 702.

83. For purposes of authorizing action under the Administrative Procedure Act, Congress explicitly has defined "person" to include a "public … organization other than an agency." 5 U.S.C. § 701(b)(2); 5 U.S.C. § 551(2).

84. Pursuant to the Administrative Procedure Act, the Court shall "hold unlawful and set aside agency action" that is: "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;" "contrary to constitutional right, power, privilege, or immunity;" or "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A)-(C).

85. The actions of Defendants in assessing, asserting, or collecting a tax against States and local governments, including Plaintiffs, are unlawful and should be set aside under each of those descriptions with regard both to the transitional reinsurance taxes already paid by Plaintiffs in 2015 and with regard to such taxes that Defendants claim the power to collect and intend to collect from Plaintiffs in 2016 and 2017.

86. Plaintiffs have no adequate administrative remedy available to them; alternatively, any further effort to obtain administrative relief would be futile.

87. Plaintiffs have no adequate remedy at law apart from this claim and action.

88. Plaintiffs are injured and suffer current harm both because Defendants illegally or erroneously have taken control of and refuse to return these monies collected from Plaintiffs, and because Defendants through their continued assertion of the power and intent to impose these taxes on Plaintiffs over the next three years have hampered and continue to hamper Plaintiffs in their budgetary and fiscal programs and planning.

COUNT 3

(Claim against all Defendants for violation of the Tenth Amendment to the United States Constitution, of Anti-Commandeering principles, and of the Intergovernmental Tax Immunity Doctrine)

89. Plaintiffs here restate and reallege each of the statements and allegations set forth in paragraphs 1-88 above.

90. Defendants' assertion of a power to tax the States and their instrumentalities directly, and thereby have them function both as tax assessors and as tax collectors for the federal government who are to raise money from the people of Ohio and then turn it over to the federal government for the administration of federal programs (including programs to be funded

out of the general fund of the United States Treasury), violates fundamental constitutional principles of federalism.

91. As Justices Roberts, Breyer, and Kagan have emphasized in the context of this very same Act, "'the Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress' instructions.'" *National Federation of Independent Business et al. v. Sebelius*, 132 S.Ct. 2566, 2602 (2012) (opinion of Roberts, C.J.), quoting *New York v. United States*, 505 U.S. 144, 162 (1992).

92. "Otherwise the two-government system established by the Framers would give way to a system that vests power in one central government, and individual liberty would suffer." *Id.* at 2602.

93. Thus, the courts will "strike down federal [action] that commandeers a State's legislative or administrative apparatus for federal purposes." *Id.*, citing *Printz v. United States*, 521 U.S. 898, 933 (1997); *New York*, 505 U.S. at 174-175.

94. "Permitting the Federal Government to force the States to implement a federal program would threaten the political accountability key to our federal system. '[W]here the Federal Government directs the States to regulate, it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision.'" *Id.*, quoting *New York*, 505 U.S. at 169.

95. Nowhere is this principle more true than in the realm of taxation, where incentives to divorce authority from accountability are at their zenith.

96. The Constitution precludes the federal government from commandeering States and local governments, including the Plaintiffs here, to serve the tax collection purposes into which Defendants have dragooned them.

97. Defendants' actions as set forth above violate structural protections of the United States Constitution, including the Tenth Amendment, and violate the related Intergovernmental Tax Immunity Doctrine and the Anti-Commandeering Doctrine, and must be set aside and redressed through judgment of this Court.

PRAYER FOR RELIEF

98. Plaintiffs therefore respectfully request that this Court:

- enter judgment in their favor on each count of this Complaint;
- require Defendants to refund to each Plaintiff the full amounts illegally collected from them and to return to the State of Ohio and its instrumentalities all monies collected from them under the claimed authority of the transitional reinsurance tax;
- require Defendants to set aside any and all regulations, directives, or instructions purporting to apply the transitional reinsurance tax against State or local government entities;
- enjoin Defendants from seeking to collect the transitional reinsurance tax from the State of Ohio, its local governments, and their instrumentalities; and
- provide all further relief that equity demands or counsels.

Respectfully submitted,

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To: Subcommittee on Oversight, Ways & Means Committee

I am submitting this letter in my own capacity, in response to the call for comments in connection with the May 20 subcommittee hearing, "Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act." My scholarly research has revealed several circumstances where IRS regulations issued under Section 36B of the tax code plainly contradict the statute. I summarize these instances of IRS overreach below, so as to aid the Subcommittee's understanding of administrative actions in the implementation of the Affordable Care Act.

1. *Extension of Credits to Persons Outside of Statutory Income Range.* Section 36B plainly provides premium tax credits to citizens only when their household incomes come with a specified income range (100 to 400 percent of the poverty line). IRS regulations disregard the statutory limitation and grant credits to potentially several million persons below the 100 percent statutory floor. The extension of this credit may trigger or increase penalties on employers.

2. *Extension of Credits to Some Low-Income Unlawful Aliens.* Section 36B allows aliens to enjoy premium tax credits even though they fall outside of the statutory range, when those aliens themselves lawfully reside in the United States. However, IRS regulations contradict the statute and allow unlawful aliens to receive premium tax credits in some circumstances.

3. *Extension of Credits to Persons Receiving Employer-Sponsored Minimum Essential Coverage.* Section 36B denies credits to persons who receive minimum essential coverage from their employers. However, IRS regulations allow for such persons to enjoy premium tax credits when those persons are automatically enrolled in employer coverage. This extension of the credit may increase penalties on employers.

The IRS's amendments to Section 36B would likely be reasonable if it exercised legislative authority. However, the agency does not enjoy the power to re-write Section 36B to reflect the law that it thinks the Congress should have been enacted.

I have attached a draft article that more fully addresses Points 1 & 2 above. The article will be published soon with Bloomberg BNA. Point 3 is more fully addressed in a blog post at the *Yale Journal of Regulation* website and can be viewed here: http://tinyurl.com/ACAautoenroll .

I thank the Subcommittee for its consideration of these comments.

Sincerely,

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DRAFT
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Lurking Challenges to the ACA Tax Credit Regulations

Andy S. Grewal[*]

Introduction

By the end of its current term, the Supreme Court will decide *King v. Burwell* and address whether the Section 36B[1] premium tax credit extends to purchases of health care policies made on federally established exchanges.[2] The stakes of the litigation are high because only 14 states have set up their own health insurance exchanges, for which the availability of credits is not disputed.[3] If the challengers to the Treasury's regulation win,[4] millions of individuals will lose out on tax credits that they relied on when purchasing policies on federal exchanges. This could lead to a collapse[5] of the entire Patient Protection and Affordable Care Act (ACA),[6] popularly referred to as the ACA or Obamacare.

However, even if the government wins *King v. Burwell*, there remain potential challenges to the Treasury's rulemaking under Section 36B. A Treasury regulation that extends premium tax credits to individuals whose household incomes fall below the floor established by Section 36B(c)(1)(A) lacks statutory authority.[7] Another Treasury regulation that extends those credits to some unlawful aliens suffers from a similar infirmity.[8]

This article explains the legal problems with the Treasury's extension of premium tax credits to some low-income individuals and unlawful aliens. The goal here is not to attack the ACA, whose wisdom I am not qualified to pass on.[9] Nor do I wish to present some philosophical

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[*] Andy S. Grewal is an associate professor at the University of Iowa College of Law.

[1] Except when noted otherwise, Section references are to the Internal Revenue Code of 1986, as amended (26 U.S.C.).

[2] King v. Burwell, 759 F.3d 358 (4th Cir.), *cert. granted* 135 S. Ct. 475 (2014). Standing alone, § 36B(b)(2)(A) refers to credits only for persons "enrolled in through an Exchange established by the State," but the government argues that related statutory provisions support its view, reflected in regulations, that credits are available for purchases of policies on federal exchanges. *See* Treas. Reg. § 1.36B–2(a)(1) (providing tax credit eligibility to anyone "enrolled in one or more qualified health plans through an Exchange") *and* Treas. Reg. § 1.36B–1(k) (defining "Exchange" to include federally established exchanges).

[3] Kaiser Family Foundation, State Health Insurance Marketplace Types, 2015, http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ (last visited April 12, 2015) (describing marketplace attributes in each state).

[4] See generally Adler & Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 Health Matrix 119 (2013).

[5] Brief for Respondent at 11-13, 23-27, King v. Burwell, No. 14-114 (U.S. filed Oct. 2014) (describing in detail the implications of an adverse ruling). But see Joel M. Zinberg, "A King v. Burwell ruling for the plaintiffs may not equal death spirals," Inside Sources (Mar. 31, 2015).

[6] Pub. Law No. 111-148, 124 Stat. 119 (2010).

[7] *See* Treas. Reg. § 1.36B-2(b)(6), discussed *infra* Part II.

[8] *See* Treas. Reg. § 1.36B-2(b)(5), discussed *infra* Part III..

[9] *Compare, e.g.*, Timothy Jost, *If The ACA Were Repealed, Just What Would Replace It?*, Health Affairs Blog (Apr. 14, 2015) (listing some achievements of the ACA and arguing that it "has been largely successful" in accomplishing stated goals), *with* Michael Cannon, *50 Vetoes: How States Can Stop the Obama Health Care Law*, Cato Institute White Paper (Mar. 21, 2013) ("President Obama's health care law remains harmful, unstable, and unpopular.").

objection to the extension of health care to our country's most impoverished individuals. (Who could be against such a thing?) Instead, I wish to use Section 36B to highlight the pitfalls associated with the Treasury's failure to recognize limits on its administrative authority.[10]

The ACA has become such a hot button issue that some will view any criticism as an inherently political attack. There is nothing that I can do about those with such a jaundiced view. But I hope that others will find that this article furthers their understanding of Section 36B and the administrative challenges related to making health care accessible to low-income individuals

I. "Applicable taxpayers" and Low-Income Individuals

Under Section 36B(a), an "applicable taxpayer" receives a tax credit determined by her premium assistance amount for a taxable year. The premium assistance amount generally depends on the premiums paid by the taxpayer for her and her dependents' health insurance coverage.[11] As household income rises, the taxpayer's credit generally shrinks.[12]

Section 36B(c)(1)(A) specifically defines "applicable taxpayer" and therefore the type of person eligible for the credit. The statute limits the term to "a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved." In other words, a taxpayer can enjoy a premium tax credit only if her household income hits a floor (100 percent of the relevant poverty line amount) but does not cross a ceiling (400 percent of that amount).[13]

Although it might seem odd to deny credits to taxpayers with the lowest levels of income, Congress contemplated that Medicaid would cover them. The ACA essentially commanded states to provide Medicaid coverage to individuals with income up to 133 percent of the relevant poverty line amount.[14] This reflected a significant expansion of prior law, under which some states offered Medicaid only to individuals whose income fell significantly below even the 100 percent amount.[15]

However, in *NFIB v. Sebelius*, the Supreme Court found that the severe consequences associated with a state's failure to expand Medicaid (loss of significant federal funding) reflected unconstitutional Congressional coercion.[16] Consequently, states can reject Medicaid expansion

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[10] *See also, e.g.*, Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,381 (May 23, 2012) (acknowledging that § 36B(c)(2)(C)(iii) flatly denies premium tax credit for any month in which employee pays for and obtains minimum essential coverage under employer plan, even if such coverage is unaffordable or does not provide minimum value, but breaking from statute and proposed regulations to "clarify," in Treas. Reg. § 1.36B-2(c)(3)(vii)(B), that § 36B(c)(2)(C)(iii) does not apply in some circumstances where employee obtains coverage via automatic enrollment).

[11] *See* § 36B(b)(2).

[12] If § 36B(b)(2)(A)'s limitation does not apply, the premium tax credit will generally be determined by the cost of a silver plan over the applicable percentage of the taxpayer's household income, and the applicable percentage increases as household income rises. *See* §§ 36B(b)(2)(B) & (b)(3). A taxpayer's household income generally includes his modified adjusted gross income along with the aggregate modified adjusted gross incomes of the persons for whom he is allowed a deduction under § 151. For further relevant definitions, *see* § 36B(d).

[13] The poverty line amounts are determined by reference to Social Security law. *See* § 36B(d)(3)(A).

[14] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601 (2012) (discussing Medicare expansion).

[15] *See id.* ("On average States cover only those unemployed parents who make less than 37 percent of the federal poverty level, and only those employed parents who make less than 63 percent of the poverty line.").

[16] *Id.* at 2604 (2012) ("[T]he financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'—it is a gun to the head. § 1396c of the Medicaid Act provides that if a State's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that 'further payments will not be made to the State.'").

without losing federal funding. Several million individuals now earn too much income to qualify under their state's non-expanded Medicaid program but earn too little to enjoy premium tax credits under Section 36B. These individuals fall within the so-called Medicaid coverage gap.[17]

II. Regulatory Expansion of Section 36B(c)(1)(A)

Under Treas. Reg. § 1.36B-2(b)(6), an individual qualifies as an "applicable taxpayer" and can enjoy the premium tax credit even if his household income falls below the 100 percent statutory floor. This rule applies when the taxpayer or his family member enrolls in a plan on an exchange, the exchange estimates his household income falls with the 100-400 percent statutory range, advance credits are authorized and paid, and the taxpayer would qualify under the statute if the 100-400 percent limitation did not apply.[18] These taxpayers generally receive larger credits than do those who actually meet the statutory criteria.[19]

The regulation addresses an imperfection in the tax credit regime.[20] Under Section 36B, an applicable taxpayer's premium tax credit depends on her household income for a taxable year.[21] However, taxpayers generally purchase health insurance during open enrollment seasons, well in advance of the close of their taxable years. Consequently, taxpayers may enroll in health plans and receive advance payments of their premium tax credits without knowing whether they are in fact eligible for those credits.[22]

Under Section 36B(f), taxpayers generally must repay any excess credits that they received. But Treas. Reg. § 1.36B-2(b)(6) contradicts that rule. The regulation allows a taxpayer to fully keep her tax credits even if, at the close of the taxable year, the taxpayer's household income did not meet the statutory floor and the taxpayer was not entitled to any credits.[23]

As a matter of abstract policy, the Treasury regulation seems reasonable. But under the familiar *Chevron* framework, reasonableness depends on the agency's construction of the governing statute. And here, the statute leaves no room for interpretation: An applicable taxpayer includes only individuals whose income meets the 100 percent floor but does not cross the 400 percent ceiling. Wisely or not, "Congress has directly spoken to the precise question at

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[17] *See* Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid (2015)* (noting that 22 states chose not to expand Medicaid and about 4 million poor uninsured adults fall into the Medicaid gap).

[18] *See* Treas. Reg. § 1.36B-2(b)(6)(i)-(iv).

[19] *See* Treas. Reg. § 1.36B-2(b)(7), under which the credit for beneficiaries of the special rule is computed by reference to taxpayer's actual household income rather than the 100 percent statutory floor, *and* § 36B(b)(2), under which lower levels of income generally increase the premium assistance credit amount, such that a person with (for example) household income at the 57 percent amount will receive a greater credit than someone at the 100 percent amount. Aside from household income, other factors influence the size of the credit, including the cost of the plan in a particular locality and the scope of desired coverage (e.g., coverage for spouse or dependents). However, in absolute dollar terms, and holding all else equal, Treas. Reg. § 1.36B-2(b)(7) effectively provides the largest tax credits to persons who do not satisfy the statutory criteria.

[20] *See generally* Lawrence Zelenak, *Choosing Between Tax and Nontax Delivery Mechanisms for Health Insurance Subsidies*, 65 Tax L. Rev. 723, 733-37 (2012) (questioning whether current year income reflects the proper standard for determining premium tax credit allowances).

[21] *See* § 36B(b).

[22] Taxpayers need not apply the full amount of their estimated credits to their monthly premiums.

[23] Taxpayers described in Treas. Reg. § 1.36B-2(b)(6) could even receive tax refunds if their premium assistance amounts exceeded their advance payments, which seems quite possible given the special rule in Treas. Reg. § 1.36B-2(b)(7).

issue," and a "court, as well as the agency, must give effect to th[at] unambiguously expressed intent."[24] Because Treas. Reg. § 1.36B-2(b)(6) contradicts the congressionally prescribed criteria, it reflects an impermissible interpretation of the statute.

The Treasury indirectly acknowledged this when it responded to public comments on the premium tax credit regulations. In its Notice of Proposed Rulemaking, the Treasury stated that Treas. Reg. § 1.36B-2(b)(6) would merely "clarify" that individuals outside of the statutory range could enjoy premium tax credits.[25] In response, commentators urged the Treasury to expand the regulation such that individuals whose actual household incomes exceeded the statutory range would also get to keep their credits, if those individuals received advance payments in circumstances similar to those described for low-income individuals.[26] However, the Treasury rejected those comments, concluding that they ran "contrary to the language of section 36B."[27]

It's hard to reconcile Treas. Reg. § 1.36B-2(b)(6) with the Treasury's response to the commentators. The Treasury would not provide tax benefits to individuals whose incomes exceed the 400 percent ceiling because doing so runs contrary to the statute. Yet the Treasury maintains that individuals with household incomes below the 100 percent floor may qualify as applicable taxpayers. In other words, the Treasury thinks that it's ambiguous whether a taxpayer at the 99 percent level comes within the 100-400 percent statutory range but that a taxpayer at the 401 percent level unambiguously exceeds it.

A court probably won't have trouble seeing the similarity between the situations. Taxpayers outside of the statutory range, whether at the high end or the low end, do not qualify as applicable taxpayers and are not entitled to premium tax credits. Nothing in Section 36B allows the Treasury to rewrite the criteria for qualifying as an applicable taxpayer.

In arguing that the Treasury should indirectly expand the availability of premium tax credits, one group relied on Section 36B(g)(1).[28] That statute authorizes regulations providing for "the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412" of the ACA. But the group misunderstood the direction of the statutory scheme.

Section 36B(g)(1) does not contemplate that premium tax credits are available whenever a taxpayer gets an advance payment. Instead, it contemplates that advance payments will be made for credits that are "allowed under this section [36B]." The statute's plain language reiterates that Section 36B governs credit determinations. If the fact of an advance payment fixed a taxpayer's right to a tax credit, much of Section 36B would be pointless.[29] Section

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[24] Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842-843 (1984).

[25] Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931, 50,934 (Aug. 17, 2011) ("The proposed regulations clarify the treatment of a taxpayer who receives advance credit payments but has household income below 100 percent of the FPL for the taxable year.").

[26] *See* Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,378 (May 23, 2012) ("Commentators requested that the final regulations treat a taxpayer whose household income exceeds 400 percent of the FPL for the taxpayer's family size as an applicable taxpayer if, at enrollment, the Exchange estimates that the taxpayer's household income will be between 100 and 400 percent of the [poverty line] for the taxpayer's family size and approves advance credit payments.").

[27] *See id.* at 30,378.

[28] *See* AFL-CIO Criticizes Proposed Health Insurance Premium Tax Credit Regs, 2011 TNT 220-24 (arguing that § 36B(g)(1) allows for the Treasury to limit repayment obligations under § 36B(f) when a taxpayer's circumstances change during the taxable year).

[29] *See, e.g.*, § 36B(f)(1) (reducing allowable credit on account of advance payments); § 36B(f)(2)(A) (requiring repayment [i]f "the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable

36B(g)(1) does not authorize regulations allowing individuals to keep whatever advance payments they receive, and the Treasury properly rejected the group's comments.

Although this result may seem harsh, Section 36B(f) provides significant relief for poor individuals. If a taxpayer whose household income falls below the 200 percent poverty line amount receives advance payments that exceed the credit properly allowed, her repayment obligation will be limited to $600.[30] One need not qualify as an applicable taxpayer to enjoy the benefits of this limitation, and a low-income individual will not face thousands of dollars of tax credit repayments.

Of course, repaying even $600 may impose severe hardships on taxpayers with few dollars to spare. However, the Treasury regulation encourages behavior that may lead to bigger problems. Under the regulation, a taxpayer who believes that he will fall short of the floor may be encouraged by an unscrupulous tax advisor or enrollment counselor to engage in unethical behavior and inflate income, especially if she is caught by the Medicaid coverage gap.[31]

The ACA, however, contains extraordinary penalties for those who negligently or intentionally supply incorrect information to an exchange. Under Section 1411(h)(1) of the ACA, an individual who negligently provides incorrect information when enrolling on an exchange faces a $25,000 penalty, and someone who intentionally provides incorrect information faces a $250,000 penalty.[32] To the extent that the IRS actually enforces these crippling provisions, taxpayers encouraged by Treas. Reg. § 1.36B-2(b)(6) to inflate income may face problems much more severe than those associated with being caught in the Medicaid gap.

Also, unlike other regulations that provide benefits to taxpayers, Treas. Reg. § 1.36B-2(b)(6) could face judicial challenge. Sections 4980H(a) & (b) impose penalties on large employers who fail to offer health coverage or who fail to offer affordable minimum essential coverage.[33] Those penalties are triggered or increased when a full-time employee receives a Section 36B tax credit for her purchase of a health policy on an exchange.[34] Because the regulation expands the scope of applicable taxpayers and therefore the persons eligible for the credit,[35] it increases the number of individuals who might trigger the Section 4980H(a) penalty or increase the Section 4980H(b) penalty.[36] In appealing the assessment of any penalty,[37] an employer can argue that the regulation invalidly extended a credit to a full-time employee.

Care Act for a taxable year exceed the credit allowed by this section"). The various provisions related to current year tax attributes would also be pointless, because exchange estimates depend on prior year attributes.

[30] *See* § 36B(f)(2)(B)(i) (prescribing a maximum $600 tax liability increase for persons whose household income is less than 200 percent of the relevant poverty line).

[31] *See also* Jack L. Millman, Gambling for Healthcare, 76 Ohio St. L.J. (2015) (suggesting an "absurd tax planning" technique under which poor persons may use wagering activities to inflate household income and arguing that this "illustrate[s] the perversity of the current situation and the need for Congress or states to act").

[32] The reasonable cause defense applies to the negligence penalties. *See* ACA § 1411(h)(1)(A)(ii).

[33] *See* § 5000A(f) (defining minimum essential coverage).

[34] *See* §§ 4980H(a)(2) & (b)(1)(B). The receipt of a cost-sharing reduction under § 1402 of the ACA of the ACA may also trigger a penalty.

[35] The annual household income of most full-time employees probably exceeds the 100 percent poverty line amount, such that the regulation will not apply to them. However, a full-time employee's annual household income may fall below the poverty line amount if, for example, he has a large family or if he is employed for only a few months during the year.

[36] For employers who do not offer health coverage, the allowance or payment of a credit for a single full-time employee triggers a penalty based on the number of the employer's full-time employees. *See* § 4980H(a). For an employer who offers some type of health coverage, the penalty depends on the number of full-time employees who are actually allowed or paid credits. *See* § 4980H(b). If, for a given month, an individual can obtain affordable

III. Regulatory Expansion of Section 36B(c)(1)(B)

Although Section 36B(c) generally denies applicable-taxpayer status to individuals below the 100 percent poverty line, the statute contains a special rule for some individuals lawfully present in the United States. Under Section 36B(c)(1)(B), a lawfully present alien with household income below the 100 percent amount who is ineligible for Medicaid by reason of her alien status will be treated as if her household income were equal to the 100 percent amount.[38] Unlike very low-income citizens, whom Congress thought would obtain Medicaid coverage, some low-income lawful aliens may enjoy premium tax credits under Section 36B.

Treasury regulations, however, expand the statute and provide tax credits to individuals not lawfully present. Under Treas. Reg. § 1.36B-2(b)(5), the special rule applies when "the taxpayer *or a member of the taxpayer's family* is lawfully present in the United States," and "the lawfully present taxpayer *or family member* is not eligible for the Medicaid program." The italicized language, not found in the governing statute, allows the lawful status of a family member to qualify an unlawful alien as an applicable taxpayer.

The regulation's preamble offers no explanation and cites no authority for going beyond the statutory language, but policy objections to Section 36B(c)(1)(D) might have prompted the Treasury to act. Under that statute, an individual for whom a section 151 deduction is allowable to another person cannot take the premium tax credit. Consequently, if a lawfully present alien obtains health coverage but is the dependent of an unlawful alien, the statute denies the availability of the credit. The regulation overrides the statutory limitation and effectively permits a credit in these circumstances.

Once again, the Treasury regulation seems reasonable as a matter of abstract policy. But Section 36B(c)(1)(B) does not present any interpretive gap for the Treasury to fill. In precise terms, Congress crafted a special rule that treats an alien whose household income falls outside of the statutory range as an applicable taxpayer only if the alien himself enjoys lawful status, and it specifically denied credits to dependents.

Nonetheless, it seems doubtful that a judicial challenge to Reg. 1.36B-2(b)(5) will arise. The Section 4980H penalty is triggered or increased when an employee obtains a tax credit for his own coverage on an exchange.[39] The regulation, however, extends credits to dependents of employees, not employees themselves. Consequently, it seems unlikely, though not impossible, that Reg. 1.36B-2(b)(5) will lead to further employer penalties.[40]

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minimum essential coverage through her employer, she will not be eligible for a § 36B credit for that month. *See* §§ 36B(c)(2)(A)-(C).

[37] *See* § 1411(f)(2)(A) of the ACA (directing the HHS to establish a "separate appeals process for employers who are notified . . . that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee"). HHS procedures are in addition to the appeal rights generally found in the tax code. *See id.*

[38] Under many Medicaid programs, aliens become eligible for benefits only after the expiration of a 5-year waiting period. *See generally* Karla Guerrero, *Waiting Five Years for Healthcare: How Restricting Immigrants' Access to Medicaid Harms All*, 21 Annals Health Law Advance Directive 109 (2011); Vinita Andrapalliyal, *"Healthcare for All"? The Gap Between Rhetoric and Reality in the Affordable Care Act*, 61 UCLA L. Rev. Discourse 58 (2013).

[39] *See* Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 8,544, 8,544 (Feb. 12, 2014) ("[C]overage for a dependent only will not result in liability for the employer under section 4980H.").

[40] The regulation might lead to an employer penalty in some highly convoluted circumstances, such as where the unlawful alien and the dependent lawful alien are both full-time employees of the same employer and other

Any blowback to the Treasury for contradicting the statute will likely be political. Literally speaking, the regulation allows unlawful aliens to obtain tax credits, and issues related to unlawful aliens reflected a controversial issue during debates over the ACA. The statute itself allows unlawful aliens to take credits on behalf of lawful family members when household income falls within the 100-400 percent statutory range,[41] but a further extension of credits without statutory authority could raise the ire of some lawmakers.

Conclusion

As the Treasury and other agencies issue guidance under the ACA, more and more problems in the statute come to light. Current regulations reflect a desire to implement the ACA as the Treasury thought it should have been drafted, rather than as it was drafted. In the long run, it's doubtful that a complex statute can offer stability if agency guidance contradicts fundamental provisions, especially given the shifting priorities and viewpoints of different administrations.

Administrative regulations that lack statutory foundation also jeopardize those who rely on them. Ordinarily, no one enjoys standing to challenge beneficial tax regulations.[42] But the ACA's structure pits taxpayers against each other, where a credit to one class of persons triggers or increases penalties on another class.

Going forward, the Treasury should re-consider its unilateral approach to the ACA. The current legislative majority might not seem amenable to the amendments that the Treasury has effected by regulation, but no canon of statutory construction expands an agency's authority upon a showing that it is acting against the will of Congress. To amend Section 36B and provide health care to our society's most vulnerable individuals, the Treasury should do everything possible to reach a compromise with our elected representatives.[43]

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requirements are met.

[41] § 36B(a) does not carve unlawful aliens from its general rule. However, such persons cannot legally obtain coverage for themselves on an exchange. *See* Treas. Reg. § 1.36B-2(b)(4).

[42] Somewhat perversely, invalid regulations that provide benefits to low-income persons may give rise to challenges, but taxpayers will lack standing to challenge invalid regulations that provide benefits to large employers. *See, e.g.*, Treas. Reg. § 54.4980H-5(e)(2) (although § 4980H(b) imposes a penalty for failure to offer affordable minimum essential coverage, and receipt of premium tax credit by an employee increases the penalty, an employer that provides unaffordable coverage will be exempt from penalty under various nonstatutory safe harbors).

[43] *See* Jonathan Adler, *How the IRS repeatedly rewrites Obamacare tax credit provisions*, Wash. Post Volokh Conspiracy Blog (Apr. 14, 2015) ("Congress has already made over one dozen changes to the PPACA that have been signed into law, and there is no reason it could not make others."); Zelenak, *supra* note 20 at 727 (noting that Congress has twice amended I.R.C. § 36B(f) advance payment reconciliation rules).

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